Divergence and Devolution

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The Constitution Unit

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

The Nuffield Trust
The Nuffield Trust for research and policy studies in health services was established by Viscount Nuffield in 1940. Today the Trust acts as an independent commentator on the UK health scene and the National Health Service. It has set out to illuminate current issues through informed debate, meetings and publications and has also commissioned research and policy studies aimed at the development of policy and improvement of health services.

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Foreword

In 1997 the Nuffield Trust, as part of its programme of work on the changing role of the state and the machinery of government for health and health care policy, awarded a grant to Robert Hazell and Paul Jervis of the Constitution Unit at University College London to review the prospects of devolution and health for the UK.

This report from Scott Greer is an important contribution to recording the early identification of divergence of policies and priorities amongst the UK family of health services. It is a contribution to our knowledge in that no one, until now, has tried to compare the four systems, either in their organisational changes or in what they say or what they are doing. This report brings together and interprets the evolution of organisation in the four systems, taking advantage of the fact that comparative health policy almost never has four systems diverging from such a common base, each experimenting with their alternatives. It is a step towards understanding how four political systems work and what each can learn from the others.

This a valuable document, useful to practitioners and analysts who want to know what is happening to health care organisation in each country and what it should mean; and it forms a foundation for further empirical studies.

John Wyn Owen CB
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1 *Framing health policies*

NHS organisation in the United Kingdom has broadly undergone four phases. While the outlines of the resulting policies have been increasingly adapted to fit Northern Irish, Scottish, and Welsh administrative structures and preferences, and their implementation has been greatly affected by their national political and administrative variations, the intellectual history of the NHS has strong common elements. These elements frame an analysis of the politics of divergence in British health care today.

The issues at stake fall along two axes: the extent to which the health service is designed to permit deliberate planning of resources, and the extent to which health policy includes the wider determinants of health beyond the health services. Planning capacity, here, means having the policy tools available to project needs and resources and then choose among policy alternatives with that in mind - in health care, this most of all means deciding how and when to invest in specialism, acute care, and facilities for expanding needs. Its flaws are well known, and talked up by proponents of its main rival, resource distribution through the market. Distribution through the market selects buyers and presumes that they, rather than planners, can most efficiently process information about needs and thus allocate resources through their purchasing decisions. The second axis is the extent to which the policy actually focuses on the organisation and activity of the Service rather than broader health outcomes. Historically the NHS has been primarily a service working to treat patients according to the medical model, but in the late 1990s public health began to revive as a serious campaign to expand health concerns beyond treating sickness.

1   The common genes

In the first phase of its history, the NHS was an amalgam of previously existing structures, with professions treated as separate units, hospital autonomy within a vertical structure, and GPs as independent contractors. This arrangement clearly showed the political compromises inherent in constructing such an ambitious system; the organisations that made up medicine were scarcely touched (Webster, C. 1998:15-30; Klein 2000:13). Getting them to participate was enough without also threatening their control over their self-definitions, roles, and internal organisations. The problem with this structure is that it introduced needless bureaucracy while making planning very difficult. Between the high degree of acceptance of the NHS among the professions, the obvious inequalities and inefficiencies of the old system, and the imposing executive capabilities of governments under the Westminster system, it was possible to dramatically rationalise the structure of the NHS in 1974 (and simplify the English structure further in 1983).

Professional's Professionalism

In this second phase, the NHS was arguably one of the best-designed health care organisations in the world. Stripped of most of the structures left over from the pre-1948 political economy of medicine, it instead was organised around the social structure of

medicine. If aligning professional and administrative structures is the key to good design, then the NHS was a very well-designed organisation. The most visible emblem of this orientation was the reliance on 'consensus management' in which representatives of each profession had to agree almost any management decision; it was literally impossible to identify who ran much of the NHS (The Griffiths Report - DHSS 1983 - that led to the 1983 reforms noted that if Florence Nightingale were to carry her lantern around the NHS, 'she would undoubtedly be looking for the people in charge'). Much of the practical import of the strategy appeared in its design by organisational theorists at Brunel University led by the MD/PhD Elliott Jacques, which was based on analyses of decision-making in medicine and which attempted to allocate powers to the level where decisions should or had to be made.

This created an organisation whose structure could look very different from different points of view. The vast majority of rationing and other decisions were pushed down to the front line professionals, creating tremendous local flexibility. Purchasing of most equipment was also generally done on a local level, as was internal organisation. The powerful regions were organised around tertiary care provision, reflecting medical hierarchies. Planning, the activity of least interest to professionals, was pushed upwards towards the centre. An emphasis on planning made the NHS look Stalinist in some analyses, while an emphasis on its actual outputs made it look extremely decentralised. In either case, this was because the principle of subsidiarity *(avant la lettre)* and an analysis of decision-making meant that the professions and the formal structure of the organisation were closely aligned. What internal control there was came through broad budgets and planning (not purchasing) control from Whitehall and the social and institutional pressures of professions. In this structure, 'the shape of the total service provided by the NHS was the aggregate outcome of individual doctor's clinical decisions, rather than the result of decisions made by politicians, policymakers, planners or managers' (Harrison and Pollitt 1994:35).

The 1974 reforms also introduced significant organisational variations in NHS organisation across the UK, Scotland, Wales, and Northern Ireland (previously, the main difference had been that Scottish teaching hospitals did not have the separate governance of their counterparts). Not only did pressure for reform have longer antecedents and a stronger consensus in Scotland and Wales, they also could avoid some of the administrative problems of larger England (Webster, C. 1998:90-99). Each one smaller than some English regions, they did not need as many tiers of authority, and the three smaller systems were accordingly all simpler. Underneath the Department, England was divided into regions, then areas (the level on which family practitioners were organised), then districts (which organised most other activity). The Welsh Office took on the functions of the regional authority in Wales as well as those of a government agency, heightening the importance of the Welsh Office. Scotland omitted the regional and area tiers, and integrated family practice into districts, producing a structure that was yet more integrated. Northern Ireland struck out in a rather different direction by incorporating health care into combined Health and Social Services boards, which also operated on the district level and dealt directly with the Northern Ireland Office.

This worked well everywhere but England where the five-tiered administration looked like too much administration. In 1982 the Conservatives abolished the areas tier, consolidating their functions into the districts. Areas (and their responsibilities for family

practice) were a relic of an effort to integrate the health system with local government; the main point of areas was to have NHS units of some sort that had the same borders as local government. Therefore, by 1983 organisational charts mostly reflected size and already existing differences in the medical and political cultures of Scotland, Wales, and Northern Ireland. The basic structural attribute of the NHS - its alignment with professional structures - was universal.

The 1974 NHS system was known as 'Keith Joseph's NHS' after its ministerial designer, not yet then a Thatcherite. It was extraordinarily resilient, for by incorporating the professions in decision-making, it could survive low funding levels very well despite its formal lack of management. Professional autonomy and power within the Service also won them over to it. Since professionals made the rationing decisions, they supported the decisions with their status. Its same corporatist instincts endlessly frustrated those who wanted formal input, whether as accountability to ministers or as accountability to locals.

Nevertheless, the lack of capital investment that afflicted UK public services from the early 1970s onward collided with the technology-driven increases in the cost of medicine anywhere to create a difficult situation for governments: the NHS, to stay at international levels of quality and availability, would not just require that governments make up deferred maintenance, but also invest sizeable sums in new plant, staff, and equipment. Those were sums that the UK government, from whatever mix of constraint and preference, was not about to spend. The trend spending line, had it reflected international patterns, would have been nudged upward with increased spending each year reflecting technology (it did in all systems); instead, capital and labour spending as a percentage of GDP varied wildly but came out to be almost the same in 1974 and 1990 (Ham 1999:74). The result was a series of crises that the government at first tried to meet with introduction of managers, audits, outsourcing peripheral tasks (laundries, the kitchens), and minor charges.

However, the same toughness that made the system able to function with extremely low levels of funding also made managerial change extremely difficult. Professionalism and the NHS reinforced each other, making it difficult for consumer advocates and ministers alike to affect the system on paper, let alone in real life. Vigorous 1980s experiments with managerialism, like their predecessors, mostly demonstrated the great difficulty of opening up a hole into which management could be placed. At no little expense and effort ministers eventually created the NHS Management Executive, which was a cadre of managers who for the first time opened up the possibility of central control. The possibilities of such control, however, were limited by the colonisation of the Executive by NHS officials and Department of Health civil servants. Meanwhile, latent consequences of underfunding erupted into a spectacular beds and budget crisis in 1987 with unprecedented public condemnations of policy from the professional bodies. Prime Minister Thatcher responded with extra funding and an announcement one night on the TV show *Panorama* that a wide-ranging review of health care services would begin.

Markets

The Ministerial Review that led to the 1989 white paper *Working For Patients* (1989) and the 1990 NHS and Community Care Act, and which signally excluded the professions, was an effort to cut the Gordian knot (Butler 1992; Ham 2000:28-41). It attempted to do so by

introducing a very different structure - to shift the NHS from professional corporatism to market-based rationing. The market was introduced over serious political resistance, and the third phase of the NHS began with these so-called '1991 reforms'. This coincided with an international move towards markets as cost-containment and quality improvement devices which in some cases were to introduce new funding (and in the form of the widely distributed *Working for Patients* had great international effect - in Spanish health care, references to 'white paper' refer to this project).

The immediate problem was not whether health care was inimical to all markets (a point economists can debate). The problem was that the markets had little to do with the existing social structure of British medicine (see West 1997 for a review of the reform and its fate). Thus, the single market, already politically damaged and damaging, tripped over five forms of resistance. First, it violated tradition. GP fundholders and purchasers continued to purchase from the local hospital. Second, it increased administrative costs since contracting required a new form of bureaucracy, and contracts always inflate transaction costs. Third, it presumed the slack and choice needed in a market. A market requires a variety of options and some extra resources with which to experiment (such as venture capital); the NHS had long been pared down to running costs, meaning that the system lacked the liquid resources to experiment. It also required choice, indeed, given the need for slack, it required too much choice. This made the mimic market seem feasible in places like London, with its large number of hospitals, but it was comical when the acute services market in question was a remote hospital in a rural area with no nearby 'competitors'. Fourth, it required the possibility of market exit - the possibility that unsuccessful competitors would go out of business. Closing acute care hospitals, however, is politically very dangerous as they can muster tremendous elite, popular, and political support. Fifth, and possibly most devastatingly for the market, it collided with the functioning of medicine. Doctors' referral networks, backed up by doctors' professional judgements of each other's competence, have proved almost immune to attack in systems such as the United States that have far more coercive structures designed to produce competition. In the UK, backed up by decades of NHS organisation that allowed referral networks to almost exclusively determine patient movements, they were more than a match for policies that expected purchasers to be able to change hospital contracts and thus referral networks. Managers really had no tools to induce doctors to change referral patterns because of a mere change in hospital contracting, while GPs were inclined to use fundholding contracts as more chits with which to bargain with their old rivals, the specialists in the hospitals. The result, as Calum Paton observed, was that 'anything resembling a functioning market was the exception rather than the rule' (Paton 2000:15). Finally, the effect was to make the Service even more inward-looking, as the incentive structures were geared to make it focus on particular health care outcomes rather than participation in broader policy development.

Enforced Professionalism
What had happened with the introduction of the internal market, in the UK as elsewhere, was a shift not in the direction of the market but a shift in the direction of greater autonomy for institutions (i.e. trusts) and greater power for primary care physicians (the GPs) whose gatekeeper status helped equalise their status and clout in medicine compared to the

powerful hospital specialists (Klein 2000:198). Despite these cultural changes and some indeterminate ones in outcomes (Le Grand, Mays, and Mulligan 1998), the result was a structure that did not control costs, did not win over most major players, multiplied managers, and had little momentum of its own. The Major governments, and then New Labour, began to seek a pragmatic third way at the same time as policymakers around the world, facing the wreckage of similar schemes, began to seek a new, constructive health policy paradigm.

They found this in a return to professionalism, if not necessarily professional power. After the collapse of the market, in almost every country from the United States to Catalonia, came the resurgence of professionalism. Two new paradigms emerged: quality and the wider determinants of health. Both reflected professional recuperation of the health agenda, both stressed the development of new relationships between the state and health issues, and both shied away from managerial, market-based solutions in favour of technical strategies intended to produce health directly. As policy options, they are very similar: they represent a victory for medical professions; they place medical outcomes above other goals, portraying them as the means to efficiency; they reduce polemic by making policy more technical; they were both born in elite medical schools and recommend more science, which wins over doctors who maintain at least a theoretical commitment to science, and they both cease to treat the health service primarily as a managerial problem. Finally, since both promise efficiency through professional dominance, they both represent easier politics than the last decade has seen, even if implementing either agenda might prove much more difficult than the governments imagine.

Finally, neither managers nor markets squeezed much extra performance out of the NHS or other systems. Since expert managers failed to identify new sources of productivity, there is a case for handing the field back to the technicians who might have better ideas from different sources. Science and clinical medicine was at least less discredited within and without the system than was management. And finally, as Labour insists, a social democratic government has incentives to use quality campaigns in order to demonstrate that taxpayers will get something for their money (Webster, P. 2001). The result is that variation between systems is between these two forms of enforced professionalism, rather than in the extent of it.

One form is the quality agenda. Quality stresses health services, and seeks to re-establish faith in them and improve their efficacy by placing well-designed and enforced technical professional standards in the centre of the agenda. In the UK, quality arrived first. It began almost immediately after the 1991 reforms, under Conservative health secretaries William Waldegrave (appointed 1990, before the reforms were even being implemented), Virginia Bottomley, and Stephen Dorrell; Waldegrave's predecessor Kenneth Clarke, initiator of the 1991 reforms, described Waldegrave's remit as 'to calm it all down and be nice to the doctors' (Ham 2000:12). Its formal debut in the UK was the mild white paper *A Service With Ambitions* (1996), with its focus on partnership, public health, and evidence-based medicine, and continues still. This phase is characterised by far less theoretical definition of organisational structures and far more emphasis on outcomes. In fact, its main organisational achievement has been the proliferation and increased budgets (as well as sanctioning powers) of quality agencies such as CHI and Nice in the UK and the Health

Technology Board for Scotland and the intellectual prestige of evidence-based medicine and campaigns against variation - academic efforts to end practice variations (such as the Cochrane Collaboration) and media efforts to end 'postcode lotteries'.

This fits with a number of intellectual agendas prominently including the New Labour credo that 'what counts is what works' (cited in *The New NHS,* para. 2.4). 'What works' in health care is not obvious, and to politicians a technical agency appears to be the solution to the problem of establishing standards, as well as an immediate defence against media outcries. Quality agencies solve many people's problems, despite their almost total inability to change practice (there is scarcely a meta-analysis recommending a tonsillectomy for anything, but they continue in many places, while hospital equipment purchasing is a highly political decision that is difficult to affect without the budgeting and planning power that technology assessors lack). They have all the virtues of replacing managers and markets with professions. And as quality issues (or, better, quality and local variations) exercise the media, quality agencies could be expected to reduce the most politically hazardous activities of the NHS. Klein writes that 'If in the past politicians had sheltered behind the doctrine of clinical autonomy, in future they would shelter behind the dictates of evidence-based medicine' (Klein 2000:214).

Quality, however, is not a reconstruction of the old NHS as it remains agnostic about the distribution of rights and responsibilities. Indeed, one of the hallmarks of a regulatory scheme, as opposed to a corporatist one, is that finance and organisation are not necessarily the responsibilities of the people who are responsible for outcomes. Instead, it is effectively a regulatory structure in which outcomes, rather than service organisation or financing are the topic (hence its acceptability in the highly regulated, private-sector-dominant United States). Under this umbrella, in which the quality campaigns protect the system from scandals, grotesque misallocation of resources, and bad press, there is scope for wide variation in service organisation. Whether this is used to challenge basic models of the public sector with financial and management alterations, manage health care by the back door as in England, reconstruct the second-phase NHS (Scotland), or to de-emphasise acute care in favour of primary care (Wales) is both disguised in public and is expected to have its impact reduced by the quality agencies who will assure an acceptable output.

The second agenda that the resurgence of professionalism brought to the fore was the wider determinants of health agenda, a new turn for the old specialisation of public health. If quality-led professionalism represents a new version of an old impulse in NHS organisation, attention to the wider determinants of health is new and still insecure in the NHS. The wider determinants agenda seeks to take advantage of the fact that many government policies in areas such as transport, education, housing, social services and economic development have significant impacts on health. For example, in Scotland it is health policy to hand out fruit in schools since that both improves the children's lifelong health prospects if they eat it, and might give some of them a lifelong fruit habit that will improve their health chances. This boundary-crossing seeks to find advantages in existing government activity, bending a policy, or adding something to it, in order to gain health benefits at a lower marginal cost than investing in health services.

Both share impracticalities: the wider determinants of health depends on health services (indeed, a marginal part of the health services) intervening in other policy fields to at least

smooth their interactions with each other and health, possibly load decisions in favour of healthy alternatives, and sometimes invade core areas of policy. This is hard. The quality agenda faces even more difficult problems based in the difficulty of changing medical practice. Medical practice is the sum of millions of interactions, mostly one-on-one doctor-patient interactions. Changing it is thus enormously difficult, since it requires changing professionals' strategies and techniques, and then also requires that the patients accept and respond to these changes. Neither is remotely guaranteed, even if problems with the latter assumption are much less studied. Thus, while both are virtually overdetermined choices on the political level, that political determination might not result in serious change to the way states work.

Wider determinants of health and quality tend to complement each other. A government recoiling from the failure of the health care market has two analytically distinct problems: that of improving the functioning and outcomes of the health service, and that of improving health outcomes in the population. The former is only part of the latter - a population with bad dietary habits and polluting industrial environments can easily absorb all the efforts of cardiologists and pulmonologists without changing much. But making the health services work is a political imperative for governments. Thus, governments have cause to use both to create a professionalised health strategy that can both use quality in health services and wider determinants in public policy to improve health outcomes overall. In the UK, they deal both with the onrush of medical scandals that has hit the NHS (after decades of low spending and distraction by reorganisation), and the fact that many health problems in the UK, such as coronary heart disease, are really results of lifestyle and economic factors.

It is not surprising that the two strategies almost universally replaced the market. However, the weight of the two strategies varies and can be a telltale indicator of policy direction. Quality is a health services agenda of, by, and mostly for, the medical schools and politicians (or directed from medical schools and politicians at doctors). Wider determinants of health leads to what looks more like an agenda for government reform. Thus, the politics leading to each emphasis reveal important nuances of health policy and politics in the systems. In the systems studied here, England is focussed mostly on quality, with its wider determinants agenda in severe administrative difficulties; Northern Ireland has been unable to make much progress on either front but most of its agreed policies attend to the wider determinants of health; Scotland treads a middle ground; and Wales leans strongly toward wider determinants of health as a guiding paradigm.

The second axis is resource allocation mechanisms. Each system, viewed from this angle, has common characteristics and preferences, and the stories of their organisational changes since 1997 have been about shaping the system to meet these preferences within the common heritage of the UK NHS and the current dominant intellectual paradigms of quality and public health. The movement is between planning and market extremes. The former was the NHS until 1991; the latter is its 1991-1997 structure. Since then the systems have diverged: Scotland has reverted to planning, England has enshrined much of the logic of the market by trying to structure resource distribution through commissioning by primary care; and Wales walks a centre line while Northern Ireland's most challenging ideas (seen in the Hayes report, DHSSPS 2001b) focus on how to plan, not whether.

Divergence

The actual ways in which the policymakers of the UK, and then of the four UK administrations, dealt with their legacies of the market and the concrete and intellectual problems of health policy began to vary as soon as the Conservative government was voted out in 1997. This essay analyses them through one particular prism: that of government documents, the white and green papers that seek to think out policy and explain how a system should work. It takes advantage of the fact that one common trait of all four systems, stemming from their common UK heritage, is a tendency to produce coherent documents explaining what a policy is about (and, if nothing else, making it relatively easy to identify a weakly reasoned policy). It identifies the trajectory of each health care system, and developing themes of its arguments and organisational design. This method is relatively flattering to the systems, as it lets the documents' drafters define the terms; but it brings out the basic continuities of predisposition. As choices come up, each administration is clearly choosing differently, and moreover each administration does its best to bring different aspects of system design onto the agenda.

2 The baseline: the 1997-1998 white papers

While the concept of a third way has been widely criticised as vacuous, part of its enduring intellectual legitimacy probably arises from the particular logics of political change in the United Kingdom, where during the 1980s relatively rigid corporatist structures were abruptly converted to exercises in privatisation theory. This polarisation left open a wide range of reasonable policy alternatives in between, something less common in other states whose less polarising political systems have left them with less widely separated policy alternatives.

By the mid-1990s there was substantial convergence between the Conservatives and Labour (Ham 1999:53-54) on policies and organisational principles. Both big UK parties felt the need to smooth ruffled feathers, draw back from the radical debates in favour of or against the single market, and find a pragmatic compromise that would work, or at least not lose votes (the SNP, Plaid Cymru, and the Northern Irish parties had far less incentive to think in such terms). After a period of polemics about the best policies, policymakers and practitioners, sick of constant reorganisation, were willing to consolidate existing structures in order to produce something adequate. Pragmatism began to seem a key virtue in organisational design. Despite the importance of many Labour proposals from 1997-8, the basic principles of the system were not under debate (Labour government publications picked up the Conservative government's shift from market terms like 'purchasing' to more neutral ones such as 'commissioning').

The logic of the New Labour approach was similar despite being presented and applied both differently and to different extents in Northern Ireland, Scotland, Wales and England *before* the creation of the three devolved administrations. Pursuing a third way, it sought to reinforce and rationalise the parts of the Conservative reforms that had been accepted at all while pursuing a 'what counts is what works' strategy with its concomitant move from a unitary system to a diverse system with regulatory mechanisms supervising outcomes. Designing these policies before the devolved bodies began operations means that the general baseline is similar in three of the four administrations: the Scottish, Welsh and English organisational systems for health care still reflect the application of New Labour principles to a Conservative blueprint. They are among the last major pieces of legislation to reflect the old UK model of tweaking legislation to fit regional variation, and therefore reflect the centre-periphery balances now superseded by the creation of the devolved bodies. The differences that arose then become more interesting when compared to post-devolution evolution: within the fairly narrow limits of New Labour pragmatism, the four systems had already begun to diverge along the trajectories they would follow post-devolution. This presumably reflects the fact that New Labour pragmatism also included responding to the preferences of local politicians and medical system elites. These groups thus had some say in the 1998 reforms, and the systems progressed along their preferred trajectories as their power only grew after the devolved assemblies started work.

Each of the territorial NHS systems presented its ideas in two green papers, and in the British administrations, white papers. They focussed on the development of organisation within the health services and on public health and the wider determinants of health care. These reflected two great areas of health care policy and a systematic problem for governments anywhere: the health care system (acute, primary, and long term) is a giant, high-profile set of organisations that are extremely important political actors and targets, while health care outcomes are mostly products of public health, i.e. strategies that have more to do with food, plumbing, education, regulation and civil engineering than with even front-line activities such as outreach, clinics, and the activities of GPs. Public health - or attention to the wider determinants of health - lacks the 'organisational demiurge' of health services or functional policy areas. The result is that a policy directed to change health is diffuse and requires great coordination among diverse bodies across functional lines, while a policy directed towards doing something with giant organisations such as the NHS does more to budgets and electoral outcomes than to overall morbidity/mortality rates.

The papers on the organisation of health care services were the English white paper *The New NHS: Modern-Dependable;* the Scottish white paper *Designed to Care,* the Welsh white paper *NHS Wales: Putting Patients First,* and the Northern Irish consultation paper *Fit for the Future* (which, given the vagaries of Northern Irish politics, did not terminate in an equivalent white paper or legislation). The specific organisational changes will be described in the rest of the section. However, in each case the strategy is the same: to stress quality while adapting the organisations that were in the best condition when John Major left office. Thus, for example, no white paper administratively reintegrated the trusts with the commissioning bodies. It would have cost a great deal of time and effort to abolish them, and trust managers often appreciated the extra autonomy while government appreciated the slightly increased budgetary control and blame avoidance. Thus they remained, even in Scotland where their autonomy was made a formal fiction by having them (and the primary care providers) be governed by the same board as once purchased health care from them. Its variation in part reflects the greater difficulty the Conservatives had implementing anything in 1990s Scotland and Wales; enshrining the status quo in legislation would naturally leave England with more of a market than Scotland and Wales.

Across the board, however, the regulatory focus and end-justifies-the-means logic characterised New Labour as much as its pragmatism; the plans all enshrine a diverse set of organisations not integrated into a hierarchy by financial or organisational structures. The NHS is nowhere a single, pyramidal structure. This diversity allows governments to experiment with new forms of service provision, including private contracted provision, although only in England does the government show any disposition to do so.

The twins of these plans were the 1998 white papers on public health *(Our Healthier Nation* in England, *Toward a Healthier Scotland, Better Health Better Wales)* and the Northern Irish consultation papers *Investing in Health* and *Well into 2000.* As with the white papers on health care organisation, these reflect the application of New Labour though to public health and the wider determinants of health. Public health, despite being responsible for most improvement in morbidity/mortality rates over Western history, is always something of a Cinderella. It requires co-ordinated diffuse activity that cuts across not just functional categories and political logics but also professions with very different definitions

of problems (to an engineer, a sewer is a system for removing waste; to an epidemiologist, it is a device for reducing infectious disease transmission). It also tends to require efforts to persuade the population to change its behaviour, and it is easy to ridicule soft fruit promotion campaigns or health plans that ask the population to smoke less and sleep more.

Finally, the nationalisation of the NHS in 1948 broke one of the major links between public health and health care by removing hospitals from local authority responsibilities and fully integrating them into medicine. Integrating health with social security in the old DHSS, while increasing the clout of Health by admitting the minister to the Cabinet, never provided much functional payoff due to the differences between writing cheques and running the NHS, and proved to be too much work for the minister. Social and long-term care outside Northern Ireland, and public health everywhere, was left half-in and half-out of the NHS. Policy integration between the NHS and anything, and between central and local government, proved difficult, and responsibilities landed mostly in the laps of local governments. The interesting exception to this was in Northern Ireland, where formal if not practical coordination between health and social services was achieved with the creation of Health and Social Services Boards in the 1970s.

The Conservative managerial and market reforms in Great Britain, even to the limited extent that they changed practices, exacerbated the functional distinctions which exist in any health system. Following the market logic that suggested the main purpose of each participant in a health system is to provide a service (that each person make his or her 'one-eighteenth of a pin'), the policy incentives designed to improve the provision of that service in each case encouraged a focus on that rather than on cooperation to change broad public health outcomes (Harrison and Dixon 2000:149-51). A hospital, for example, had incentives to focus on treating ailments, not performing outreach to reduce them, as services and not local morbidity/mortality rates were its designated and measured outputs. In short, public health is universally a Cinderella service, but nothing in the design of UK social policy makes it less so. Nevertheless, with the 1996 retreat from markets to quality and technocracy, public health became a major focus of both parties' politicians even as their policies remained fuzzy. It is, after all, cheaper and more pleasant for all concerned to try and reduce recourse to fish and chips than to pay for the subsequent cardiology treatments.

The rest of this section briefly analyses the three white papers, the three green papers, and the Northern Irish consultations on both topics: health services organisation and public health. In Scotland, England and Wales, the health care system is not a creation of separate legislatures but an adaptation of New Labour thought to their political and policy specificities. In Northern Ireland, on paper at least, the baseline is still the 1991 adaptation of Conservative policies to Northern Irish specificities (which, in health services organisation and in general, are very important). A signal result of this lag is that the disconnection between legislation and practice is probably far greater in Northern Ireland.

2a   England: New Labour's New NHS

The purest form of 1997-8 'third way' politics in health services organisation is the English NHS white paper *The New NHS: Modern-Dependable.* The white paper's initial claims, in the introductory chapter, present the internal market as a waste of resources that diminishes professional power, and repeatedly announces its abolition. Its second chapter, however,

starts not with organisation but with quality - a section about 'national standards and guidelines …   local measures to enable NHS staff to take responsibility for improving quality; and a new organisation to address shortcomings' (3.4). The two bodies eventually charged with producing this quality were Nice (the National Institute for Clinical Excellence, habitually written Nice), which is a technology assessment agency, and CHI, the Commission for Health Improvement. CHI's main output are National Service Frameworks, which are thematic documents on topics such as the elderly, and which set out appropriate treatment mechanisms and desired goals for medical activity including commissioning.

The centrepiece of the strategy for health care organisation was the creation of primary care groups, which represent both an acceptance of and a step back from the purchaser-provider split. All GPs are to be integrated into Primary Care Groups (PCGs), which can range all the way from advisors to local health authorities to freestanding bodies - Primary Care Trusts, or PCTs - that not only commission care but also become trusts that provide care for lesser maladies. Eventually, 75% of spending is supposed to be routed through them. Their, and the acute care trusts', outputs are to be monitored by quality organisations. Optimistically, they are an effective way to make primary care 'lead' the NHS by making GPs rather than health planners determine the services to be commissioned. In theory, this is because GPs know best and are the most cost-effective practitioners, and the sum of their decisions, rather than plans, would be the best guide to what investments would be effective. It is a market logic: the assumption runs that hospital services will grow or decline based on demand, and the aggregate demand of PCTs is a better guide than long-run projections of need.

Whether this will be fully implemented is one question. PCTs need not take over such functions from health authorities and they are already under considerable stresses from their other duties - duties that are increasingly monitored by the centre. Hospitals have no great incentive to cooperate with a policy that makes them appendages of GPs (and in interviews, English NHS staffers freely discuss their efforts to pacify hospitals by bringing them into discussions). Another question is whether the National Service Frameworks will leave the PCTs any room to make decisions on their own all remains to be seen. These frameworks, the main activity of Nice, could constrain commissioning so tightly as to effectively plan care from London. Furthermore, the effects of this universalisation of a reduced-scale form of GP fundholding might have negative effects for equity. Finally, this still leaves the NHS with little capacity to plan, and there is no assured mechanism by which the services will be there for the PCTs and health authorities to commission (or, really, to ensure that the NHS stops providing the services nobody does want to commission).

Thus, *The New NHS* bore down firmly on two points: assuring medical quality and standards; and promoting those aspects of the purchaser-provider split that appeared stable and useful to policymakers. This is the first English distinction: it more enthusiastically promotes these splits than the other three regions, reflecting the greater uptake of Conservative reforms in Southern England and the differing political climate in England. In part this is because it not just creates a path to a NHS dominated by GP commissioning; it also creates the commissioners by forcing all GPs into PCTs. *The New NHS* claims to universalise the split of purchaser and provider through PCGs while extending the power that some GPs gained with fundholding. The Scottish and Welsh papers grudgingly accept

the administrative split but (especially the Scottish) seek to eliminate it from policy. Only in England did the government seek to put the purchaser-provider split to some use. The result is a particularly pure form of a regulatory structure in which quality agencies regulate outcomes, leaving government free to experiment with various forms of provision.

2al   Public health

In public health, the relevant English white paper - and inspiration for the devolved white papers - was the February 1998 *Saving Lives: Our Healthier Nation.* This slim document's intellectual proposition was to avoid both 'individual victim blaming and nanny state social engineering' (3.2). It proposed a 'contract for health' (3.9) in which the government promised to 'provide national coordination and leadership; Ensure that policymaking across Government takes full account of health … Assess risks and communicate those risks clearly … regulate and legislate when necessary; tackle the root causes of ill health' while 'Local Players and Communities' could 'Provide leadership … Work in Partnerships to improve the health of local people and tackle the root causes of ill health; Plan and provide high quality services to everyone who needs them.' And, 'People can: Take responsibility for their own health … Ensure their own actions do not harm the health of others; Take opportunities to better their lives and their families' lives.' For all the anodyne rhetoric, *Our Healthier Nation* was an important landmark. Its analysis of public discourse was substantially correct - public health was largely invisible in policy, and the rare government interventions were often unserious, hectoring forays into lifestyle education. Viewing public health as a serious and intellectually coherent challenge requiring joint working was a sharp break, no matter the flaws of the actual document.

This contract, at once intellectually defensible and vague on details, demonstrated the difficulty of organising public health efforts. To give it some content, the government proposed four priority action areas (heart disease and stroke; accidents; cancer; and mental health) with national targets and contracts. It backed it up with some meatier organisational changes: Two were designed to promote leadership in coordinating policy (3.11): appointing a Minister for Public Health to coordinate policy across government and health impact assessments of 'relevant key policies'. Organisationally, 3.15 promised to give Government Offices for the Regions an important role in public health in order to take advantage of their coordinating roles in housing, planning, transport, training and investment in industry, a policy that the Minister would act upon later. The result was a relatively weak effort to integrate functionally distinct policy domains by producing programmes and appointed leaders who would, hopefully, modify other people's plans in order to produce public health. It did not wander into greater structural changes designed to force coordination with or without leadership and agreement, and the leadership of the Minister and Government Offices should be the major factor determining the success or failure of any actual policy interventions. The structure is good on the possibilities for building public health through policy work and coordination; it is weak on outreach, screening, and other gritty, local-level public health functions.

2b   The NHS, in its Welsh version

The Welsh white paper adapted the English primary care model to Welsh preferences and the flatter Welsh organisational structure. The Welsh NHS was made the English NHS

without the structural incentives to become dominated by primary care commissioning. In Wales, the primary care groups were not created, and instead primary care was fitted into local health groups. Local health groups have geographical borders contiguous with local government and were subcommittees of health authorities. The white paper suggested that they eventually commission care. This means their roles would eventually resemble English PCTs, (1.22-1.26) making it formally quite comparable to the English white paper. Given, however, that local health groups were formally and financially (8.3) subordinate to health authorities, the likelihood of a shift towards the English commissioning model was made extremely small: neither government nor practitioner pressure to establish primary care commissioning as the dominant model appeared likely.

Otherwise, these entities differed in two significant ways from the English model PCGs. First, they reverted towards the second-phase NHS structure in which single bodies (health authorities) can budget and plan care for a geographic region. Rather than having purchasing power concentrated in the primary care groups with closed lists of patients, purchasing power was in the hands of local health authorities who organise primary care and commission acute care. Second, the alignment of local government, local health group, and health authority borders could be important. The history of health services in the UK is filled with efforts to find a working relationship between local government and the health system, with the health system usually distanced from local governments. The Welsh legislation, by making health authorities and local government units coterminous would ease joint planning between the NHS and the social services lodged in local government. Given the long history of separation and gaps between health care and local government, this shift is interesting both as a political question (why did it happen?) and a policy opportunity (will local policy networks be strong enough to integrate health and local government?).

2bl   Public health

Better Health, Better Wales was less vague then *Our Healthier Nation* about mechanisms, relying less on leadership and more on plans (it then goes on to be vague about the internal workings of the plans). Instead of using contracts as the main mechanism, it sought to apply a command model in which local authorities and health bodies would have a duty to collaborate in the promotion of public health (1.11). This effort to play off of the new borders promised the possibility of creating new mechanisms that would locally give mandates (and thus legitimacy) to public health campaigns and signally sought to force collaboration between the NHS and local authorities. It also proposed health audits, information campaigns, and targets for health gains. The virtue of this is in part its attention to non-policy areas of public health: England concentrates on public health outside health, while Wales, in its duties of collaboration between local government and the Service, creates a firmer institutional base for gritty tasks such as outreach and screening.

The intellectual agenda that *Our Healthier Nation* suggested for England received more coherent treatment from the Welsh paper. Its five conceptual areas mostly boiled down to the same message: that health was generally determined by a range of factors amenable to policy that were outside the health service proper. Thus, the heading 'sustainable health' led to calls to integrate environment, employment, housing, leisure, health, social care,

education and other services around health. Likewise, the heading 'healthy environment' calls for improvements in environmental health, and public safety, as well as action against homelessness and bad building maintenance. The massive health impact of these factors is documented, and it presents the call to integrated policy thinking as a rational response that would over time generate gains if implemented. This intellectual coherence spelled out the extent of necessary collaboration and made the policy challenge seem as daunting as it really is.

2c   Scotland

Scotland began with a flatter structure than Wales and England, and like the others maintained the formal, administrative separation of primary care, acute care, and commissioning and the possibility that primary care take over commissioning. That said, the white paper marked yet more variation from the UK baseline than did the Welsh. While the Welsh design made a transition to an English-style structure based in PCGs unlikely and slow, the Scottish one made any such transition extremely implausible.

Designed to Care decisively shifted planning and decision-making authority away from those three groups and restored it to health boards, breaking all but completely with the 1990s' experiments in 'horizontal' market contracting schemes in which primary care, whether GP fundholders or PCGs, contracted acute care. Strategy and planning are shared by the Management Executive and fifteen health boards which organise the strategies for their regions and monitor implementation. Beneath them are the old acute and primary care trusts (their boards merged to form the fifteen health boards). The result is that the health care system was reintegrated into a single, largely vertical structure decentralised into the health boards, with policy housed in the boards and administration in their autonomous subordinate units (3.46). The result preserved the administrative demarcations of the 1991-reforms NHS, but only as the administrative form, and reintegrated major decisions into a comprehensive, vertical package that is billed as promoting integrated care (3.47). Joint Investment Funds were created as strategies to allow acute and primary care trusts to work together horizontally to common ends; anecdotal evidence suggests they did not. A Health Technology Board for Scotland (HTBS) picks up the functions of quality assurance that Nice performs in England and Wales, but its role is slightly different. In Scotland there are a distinct class of care commissioners - the fifteen Health Boards - which can both plan all care in their regions, and possibly be controlled by Edinburgh. As a result, the HTBS does not have as much potential to become the main instrument of government control, and might join most of the world's other technology assessment bodies as a fundamentally advisory organisation (note the difference in the name: it promises nothing as ambitious as clinical excellence). This is because a regulatory apparatus has far less role in a planning system such as the Scots began to develop.

2cl   Public health

If the theme of Scottish NHS reorganisation was integration of health care services, the theme of Scottish public health before devolution was voluntary cooperation, as discussed in the White Paper *Towards a Healthier Scotland.* Much of the burden of promoting public health in fact was to lie on the Health Boards which were to offer support to local authorities

and demonstrate possible reductions in public health activities through their own actions. In short, the Scottish plan resembled the English one, with leadership and assessment/coordination within government as the main strategies to achieve defined targets. While the English white paper suggested that a minister would be responsible, the Scots proposed that health boards (appointed to manage health care services) would lead the way.

In either case, neither Scotland nor England made serious efforts to force public health concerns onto the agenda of their NHS or their local governments, even though both have, by putting attention on public health, made it easier for activists within the Service to act on public health concerns. If nothing else, the English plan might make it easier for leaders to gain ascendancy by creating the dedicated minister and not lodging primary responsibility with people who are busy running health care services. On the other hand, the Scottish plans to target such problems as heart disease and unsafe sex might succeed on the back of established policy communities in the smaller and better integrated area. The advantage of lodging public health responsibility with health boards is that while it might lose policy influence, public health can use health service resources for targeted interventions to work on individual diseases or populations. If Scotland can inspire them to do this, there should be a net public health gain.

2d   Northern Ireland

The most comparable document in Northern Ireland was the consultation paper *Fit For The Future.* This paper suggested two models with a common foundation (in 3.8) that retained separation between commissioning and provision functions, abolition of GP fundholding, a greater role for primary care, and continued integration of health and social services, and while promising that 'quality will be at the heart of the new HPSS' (4.9) was vague about the mechanisms to be adopted. The document finished by proposing two options. Option 'A' (6.3-6.15) would give the Health and Social Services Boards a largely 'strategic' function while English-style Primary Care Groups would commission. This would have closely resembled the English market-oriented model and attempted to use the commissioning power of primary care to tug health care in the direction of a primary care led system. Option B (7.1-7.29) would have been closer to the Scottish planning logic. 'Local Care Agencies' would have absorbed the boards, the Health and Social Services Trusts, and much of primary care. This model would have purchasers and providers merged into these large agencies (of which there would be 6-8), effectively creating a regional planning system without 'horizontal' contracts between commissioners and providers. The response to the consultative document, while not demonstrating any clear consensus, was predictable in terms of medical politics: GPs were most likely to support Model A (of which they would be the centre) while community and voluntary sector organisations preferred model B (in which the agency would plan, and could earmark funds for social services) (DHSS 2000a).

However, unlike in the health departments of England, Scotland and Wales, the Secretary of State did not push through any decision, leaving fundholding on temporary extension when health policy was handed over to the new Assembly. Meanwhile, public health, like many other concerns, was lost in the handover to the new Northern Ireland assembly. This policy vacuum was in large part deliberate. Part of the logic of devolution to Northern

Ireland was that demonstrating to all parties the advantages of participating in local solutions would reinforce the peace process. Thus, the UK government opted to slow the rate of policy change in Northern Ireland, in order that politicians might have incentives to support and participate in devolution and that they might be able to demonstrate the benefits of Stormont. Specifically, the UK government wanted Stormont to have the opportunities to show the improvements in policy that come with accountable government in as many areas as possible. In creating this vacuum, it helped that there is little incentive for London-based British politicians to take any more risks in Northern Irish politics than they need to, and even less for them to intervene decisively in Northern Irish public policy.

2e   Summary: What New Labour did

There are distinct and interesting variations in the New Labour template for health care services organisations that on one hand responded to local preferences and situations and on the other hand strongly biased the likely eventual outcome of health care services reform. The basic template was one based on consensus and removal of the explicitly market-oriented policies in favour of building on what seemed most solid after the turbulence of the 1990s, specifically quality, administrative autonomy of separate institutions and the increased power of primary care physicians. The Scottish structure bore down on reintegrating the NHS, eliminating the barriers between services that were thrown up by the internal market and reintroducing planning. The Welsh structure was less clearly dedicated to integration and planning within the NHS. It contains the organisational raw material to join England as a structure in which funds are routed through primary care groups, but less focus on actually creating that structure. Its organisational similarity to local government makes it potentially more likely to produce integration with social services. The English structure, despite its formal commitment to abolishing the internal market, tried to build on the positive features of the purchaser-provider split. It proposed to reintegrate the NHS as a set of spokes radiating out from GPs, thereby creating a different system based not on planning but on the needs of primary care groups.

In the UK of the late 1990s, any public health strategy was radical. The English and Scots were left with a commitment to interdepartmental integration led by leaders, with the English white paper more plausibly picking out a minister and Government Offices as leaders and the Scots less plausibly relying on leadership from local Health Boards selected for their skill at health services delivery. In either case, the dependence on leadership suggests that initiatives will be distributed about as well as leaders, i.e. spottily. Wales marked a more interesting path by immediately taking advantage of its new health care services organisation. Health services delivery and local government, now sharing borders, were to be compelled to work together on local public health needs. If implemented and successful, this might overcome the suspicion and division that has marked relations between state health care and local government in the UK since the creation of the NHS. The long history of redrawing administrative borders to promote policy integration - such as the English areas hopefully created in 1974 and eliminated in 1982 - stands as a warning of the pitfalls.

The grounds for optimism, however, lie in the fact that the professional politics of public health are not like the professional politics of more classical medical professions. Public

health, if not made a branch of epidimiology as it often is in the NHS, is a highly political profession. Much of its advances are intrinsically exercises in interdepartmental, interdisciplinary, working, as it requires insinuating public health concerns and expertise into other people's work. Thus, any successful public health policy will take the form of giving local public health activists on the ground some extra support and resources with which to change local balances of power: funds to second a person into another agency's office, support for planning fora, obligations to make other agencies think about health, budget lines for dedicated staffers to win credibility locally.

In each case, what is striking is how, for the first time in Scotland and Wales, adaptation to the separate country went beyond administrative flattening and began to reflect coalitions and agendas among elites in those countries. There are many ways to be pragmatic and build on what works, and New Labour chose three slightly different ones before devolution. After devolution, each country would continue along that trajectory. The most likely explanation is that in each case New Labour had to adapt a basic intellectual blueprint to the political climate of each country. To work, a model had to receive support from the health policy elites and politicians of each country, and thus took into account the factors that would later come to further dominate health politics. In all probability, the primary care led, market-oriented English model was New Labour's goal. Scotland was most resistant, with its health policy debates biased toward reintegration, and Wales less effectively resistant, accepting the new PCG/T structure but with far less institutional momentum behind market allocation.

3   *Evolution after devolution*

The analysis of the 1997-1998 baselines is perforce an analysis of New Labour and its adaptations to the different organisation of health care services in Northern Ireland, Scotland, and Wales. After the inauguration of the Holyrood, Cardiff and Belfast bodies, however, health care policy became subject to new and different policymakers with new and different possibilities and constraints. The extent and nature of the differences in formal policy are the concern of this section.

A key to understanding devolved politics is not taking England as a baseline. It is tempting, and often a habit, to look for changes that came with devolution vis-a-vis England. This made sense under the pre-1998 unitary system when there was a UK policy with alterations in the three administratively devolved areas. Scottish civil servants stayed up late so that they could produce green and white papers the same day and time as 'UK' ones. The result was that most policies were indeed adapted versions of UK policies, and it made sense to look to London for the shape of policy and examine the variants only as data on the important policy variations.

This has changed. The great limitations of Westminster's influence over health policy *(de jure* and *de facto* in Scotland and Northern Ireland, *de facto* in Wales) means that there are now four policy arenas with four health policies in the UK. This has particular empirical relevance given the changes being made in England, which from recent indications is pursuing a more radical approach to health care organisation than the other nations (or, cynically, the Northern Irish, Scots and Welsh are breaking with the UK tradition of constant major switchbacks).

Convergence must in large part be explained by the influence of various factors as processed by the system's political structures. Divergence, meanwhile, is not a matter of Northern Ireland, Scotland, or Wales differentiating itself from a UK (English) baseline; it is any one of the four parts of the UK developing a policy that diverges from the common historical elements of, and current trends in, health policy. Naturally, there is mutual influence, but it is not unidirectional. In both the beef-on-the-bone bans and retention of Community Health Councils, Scotland and Wales changed English policy through their pressure and their example - English ministers found it hard to justify abolishing the CHCs and lifting the beef ban when their Scots and Welsh colleagues did not agree.

Furthermore, divergence need not mean good policies, or intellectually consistent policies. What is should mean is policies that reflect the inputs into and workings of the policy and political systems of the four countries. In other words, a policy failure will have to be explained by how it came about in that country's political system, just as a policy success inherently gives some credit to the country. In other words, each country has embarked upon a distinct trajectory, reflecting the policy cores and implements favoured by each government and only subject to upheaval in important cases. One way to sketch at least some of the continuities is to analyse the consistent themes in the policy documents of the governments, even in cases where it might be more appealing to analyse them as mistakes or

verbiage. Even if a single decision (say, England's abolition of the NHS Executive or Wales' abolition of health authorities) is debatable, it is at least likely to be in line with pre-existing trends in policy (in both cases, efforts to force accountability up and down, from the middle to the centre and the frontline).

Every administration but Northern Ireland has produced a health plan *(The NHS Plan* in England, *Improving Health in Wales, Our National Health* in Scotland) while Northern Ireland has produced a Draft Programme for Government *(Making A Difference),* which contains substantial health discussion, and a group of consultative papers that outline much of a health policy agenda. Plans are relatively rare in UK health policy. The historical precedent for a plan in the UK is the 1962 Hospital Plan, which, despite its flaws, promised a ten-year programme of hospital construction and contributed significantly to both modernisation of the service and the extension of the visibility, role, and status of acute-care hospitals in the UK (Webster, C. 1998:45). Labour government in England led off the plan production with *The NHS Plan: A plan for investment, a plan for reform.* Its subtitle outlines the two themes of its argument: that renewing public services would require both more funds and significant change. It promised to do this over a decade, highlighting the realistic constraints on any ambitions for one of Europe's largest organisations (Jones and Hall 2000). The Welsh and Scots followed up with their plans, which were significantly different in tone. Rather than focussing on health care organisation and the destination of funds, they sought to outline the devolved governments' approaches to health overall, with extensive discussions of joint working and many targets that are public health rather than acute-care concerns. The English NHS plan sought, in a time of expanding budgets, to design the future that the new funds would build for the NHS, while the Welsh and Scottish documents purported to lay out their individual strategies in what were health-policy declarations of autonomy. In all these cases, a plan meant something different and perhaps more inspiring than reorganisation, for planning (and the 1962 precedent) connote shaping a system for the future, determining needs and matching resources and administration to them. All had more money to do it with, given the large social services increases in the UK budgets (especially starting in Labour's third year). The ongoing operation of the Barnett formula, even despite shrinking their share of public expenditure, has left it above the English per capita average. This meant that the plans were likely to have long-lasting effects, given that they would govern what might be the last serious period of reconstruction for decades. The funds gave policymakers the slack resources to identify priorities and build them into the system with the new funds.

Much of the day-to-day activity of the NHS remained the same, because policy developments take time to build up, money takes time to have its effects, and UK cabinets before devolution set the fundamental structure of health care in each area. One striking thing has been the fate of 'partnership' and the resurgence of policy design ideas (if not grand theories); England and Scotland are particularly striking for the decreased reliance on the pragmatism of 'partnership' thinking and the increased interest in designing an NHS. Specifically, the Scottish NHS has increasingly integrated into larger organisations, while the English NHS, from the various ideas in *The New NHS,* has focused on primary care commissioning as the key to the whole system. Wales has done its share of reorganising but

also bore down on a particular feature of health care organisation that was already noticeable in the 1998 reforms: the commitment to public health and broader determinants of health. In many ways, the Welsh health plan is the most striking of the three for its virtual intellectual abandonment of the medical model of individualised disease treatment and theoretical relegation of medicine to the status of a powerful tool in a multi-pronged effort against ill health.

Northern Irish policy remained murky. Legislation from a major white paper on primary care was defeated, and there is no stand-alone plan or major legislation bearing directly on health services organisation or public health promotion, despite interesting debates on primary care and other policies (DHSSPS 2000b). Scotland and Wales continue to eliminate remnants of the market and the whole middle tier of their systems. England is entering into a new round of reforms in health care organisation and financing before having fully implemented the 1997-8 ones (or, arguably, the 1991 or 1996 ones), making it difficult to determine what the real shape of the English NHS is.

Policy debates in all four systems remained firmly grounded in the concept of quality and attention to the wider determinants of health, even if the actual seriousness of the commitment and the likelihood of real changes varied (with England primarily focused on health care services organisation, Scotland speaking of public health but still focussing on health care services, and Wales focussing on integrated public health activities and promotion). In quality, the organisations are established: Wales gets England's medical technology and quality apparatus through CHI and Nice (DoH 1998b) while Scotland's HTBS is up and running, although criticised for lack of independence compared to England. Northern Ireland has not yet been able to enact a policy, although there are interesting options in its consultation paper (DHSSPS 2001a), most of them related to the degree of independence the country should have in medical technology. This is an issue that Northern Ireland's drafters were correct to identify: the movement for quality bases itself on theoretically global concerns of effectiveness and evidence, but its decisions are inherently political and thus fodder for autonomous politics. Deciding whether to opt for formal independence, as in Scotland, or dependence, as Wales, requires deciding how much formal and institutional recognition there will be of the political nature of quality decisions.

One site of interesting differences is the role of private finance, whether a PFI (private finance initiative) or one of the various other arrangements dubbed PPPs, or public- private partnerships. In a typical PFI or PPP, the government (central or local) invites private finance and often management in to design and construct a building with government funds, which the government then leases back. This allows the government to count capital expenditure as a service purchase and might allow greater initial capital investment despite the higher commercial cost of capital. It also introduces private-sector labour practices, and there have been some brave attempts to justify the whole policy with the idea that it offloads risk onto the private sector (an assumption that posits extraordinarily talented contract writers in the public sector and poor negotiating by the contractors). Who gets the building after the contract expires, the extent of private sector management of the facility (sometimes as far as including almost all nonclinical staff) and the actual costing and apportioning of risk all vary by project, as does the justification. The costs and benefits of PFIs, as with many other public-private partnerships, and the incentives required to attract the private sector, generally remain unclear.

Due to Treasury rules and budgetary constraints, the PFI is a major instrument of the NHS physical plant expansion under each government (Ward, 2001). But in England, the government has shown many signs of pushing the issue further - bringing in private-sector firms to manage NHS clinical staff, having NHS managers take over other bits of the NHS, and hiring private-sector managers to run limited-purpose NHS facilities designed to cut waiting times for operations like hip replacements; the superior expertise of the private sector presumably justifies such large experiments. This, a new twist on 'whatever works', has something of the status of a crusade, even if unions, professionals, and many outside observers are deeply sceptical of its practical and ideological claims. Prime Minister Blair's support of it (Blair, 2001) sought to defend it in the highest-sounding rhetoric of progressive social democracy - and also noted that a car accident victim would not care if the hospital A&E was PFI. That pragmatism, a rhetorical tool of all administrations, sits ill with what appears to be a campaign grounded in firmly ideological understandings of states and markets. In Wales and Northern Ireland, such expansions of private involvement are not mooted. Scottish Labour, better linked to London than Wales and currently entangled in spending talks with the Treasury, has been confused and confusing. There were initial moves against this 'modernising' agenda from within Scottish Labour, (Fraser and Cusick, 2001). But the First Minister, Henry McLeish, belatedly signalled his support for PPPs (Public Finance, 2001), especially stressing their different ways of working - a main theme of the Blairite arguments. In Scotland and Wales these changes look like they could still become a major differentiator between Labour in the three British administrations. In both Scotland and Wales the political agendas and Labour parties are further left-wing and less amenable to control from London, the governments are coalitions with the PPP-sceptical Liberal Democrats, the health elites are better connected and further left and Labour's prime political opponents are not the Conservatives, but the left-of-centre SNP and Plaid Cymru.

3a   England

The New NHS, which was largely implemented, was followed up by *The NHS Plan: A Plan For Investment, a Plan For Reform,* a strategy document for the NHS organisation that purported to explain the uses for increased health spending. *The NHS Plan* was widely pacted, with pages of signatures from various professional representatives at the front. In part, its wider acceptability reflected the fact that participation in the plan was a positive-sum game: nobody seemed likely to lose funds from a strategy document tied to new spending. But like other plans, such as the famous if ill thought out Hospitals Plan of 1962 that still affects the physical infrastructure of the NHS, the *NHS Plan's* focus on investment means it will set the possibilities and constraints for a long time to come.

A striking, if scarcely visible, organisational feature found in the investment sections of the *NHS Plan* as well as throughout UK public policy is its insistence on the private finance initiative (PFI) presented in the plan as a mechanism to increase capital spending (4.10, 4.11). Yet more novel, and significantly more promoted, is the way the plan enshrines public-private collaboration, or more properly, private provision of NHS services at public expense (chapter 11). The paper promises a concordat with the private sector (since signed) which focuses on letting NHS clinicians and institutions purchase private facilities and

services (11.7). The somewhat obscure 11.10 then promises that the concordat 'is intended to be the start not the end of a more constructive relationship' in which the NHS will speed its progress through partnerships with the private sector, above all in imaging and pathology. The chapter concludes by arguing that this will 'contribute to winning the war on waiting for treatment in the NHS' (11.21), reflecting the publicity accorded waiting lists and periodic winter beds crises.

Otherwise, the plan sought to link the twin concerns of investment and reform to the concerns expressed in a listening exercise with staff and the public. Much of its length is concerned with using investment to reform defects in the functioning of the NHS. Thus, there is a strong focus on information technologies, continuing education, and, of course, quality as seen in clinical governance, uniform treatment possibilities, and a reduction in practice variations. NHS Direct, a 24-hour telephone medicine service, is to speed treatment and reduce pressure on primary and acute care. The plan promises to expand it with digital television and electronic information points in places like shopping centres and train stations (12.2). Between self-care, NHS direct and stronger roles for pharmacists, the government felt it could guarantee consultation with a 'primary care professional' within 24 hours.

In short, the *NHS Plan* is filled with new destinations for investment, seeking to use much of the money to enable changes in provision that will lead to a system better able to manage demand by implicit rationing by complexity (dealing with simple issues outside the GP system) that restricts highly trained professionals to very difficult tasks. It is a plan for clinical reorganisation, with much of its bulk dedicated to the changes that will be seen by doctors, nurses, patients, and the elderly. Its focus on health care services is thrown into particular relief when compared with the Welsh plan (treated below); *The NHS Plan* is a plan for the NHS, not for health. It is not necessarily inferior for that; both improving overall health, as in Wales, and improving the functioning of the NHS, as in England, are *prima facia* honourable goals. It is strikingly regulatory and target-oriented, as with other English policy. The DoH and the quality agencies will police outcomes, leaving the government free to experiment with any sort of policy it finds interesting.

While the changes from *The New NHS* and *The NHS Plan* were being launched, the government began to discuss another round of reorganisation in the English NHS - evidently betting that the disruption and cost of a reorganisation was worth whatever improvements might emerge from a hasty new design. This takes two forms, and any discussion is necessarily provisional at the time of writing (given the tendency all UK administrations share to announce major policy changes long before their rationales or details). First, the Health and Social Care Act of 2001, passed in May just before the elections, was striking for its changes to health care organisation and finance. In terms of organisation, it allowed private firms to operate and provide services formerly provided by the NHS, including with former NHS staff, leaving the nature and demand for those services up to executive decisions by the Minister and within the health system.

Finally, the Act proposed to abolish Community Health Councils, the watchdog organisations set up as a form of patient and community ombudsmen, and replace them with scrutiny by diverse bodies including local government (a novelty). The logic behind their abolition was not clear, although CHCs had led opposition to PFIs in many areas and

might have been perceived as obstructing the government's strategy for financing infrastructure. One source of public discontent with their elimination was that neither Scotland nor Wales had thought of eliminating their counterparts. While they were reprieved in the Health and Social Care Act passed just before the dissolution of the parliament, the government has made it clear that they are not part of its future plans for the health system. Notably, the fact that their abolition was not mooted outside England played in their favour, by leaving the burden of proof on the English minister to explain why CHCs were not desirable.

Meanwhile, the government in England abandoned the small-c-conservatism of *The New NHS* - working with what was working - in favour of a somewhat improvised radicalism. The new strategy, it seems, was born of frustration with the speed at which resources were changing the perceptions of front line staff and patients. Specifically, the government began to lean more and more on three points: quality, primary care commissioning, and administrative reform. The most visible change in this was the proposal to reorganise the NHS, made by Alan Milburn at an April 2001 speech marking the opening of the Modernisation Agency (the agency charged with implementing the *NHS* Plan)(Milburn 2001). In this speech, he announced proposals to shift public health concerns to Government Offices for the Regions while otherwise eliminating the NHS Executive and the Regional Offices 'over time.' In their place would be strategic health authorities created by merging two thirds of health authorities, the public health workers in government offices, and the quality agencies (regional directors of health and social care would be attached to the new 'strategic health authorities' for 'oversight' as against 'second-guessing.'). In other words, strategic thinking would be pushed down to PCTs and health authorities, while responsibility for policing them, currently an Executive function, would move up to Whitehall and the quality agencies.

The result is a new organisation chart (DoH 2001b:19, Greer 2001) that promises a 'clear line of sight' between the centre and the front line (a prospect not likely to be welcomed on the much overseen front lines). PCTs and trusts are now the basis of commissioning. Strategic Health Authorities, each composed of approximately three existing health authorities, will be pushed aside by the new importance of PCT commissioning (PCGs having become close to extinct by their upgrading into PCTs). Thus, PCT managers are worriedly facing the new prospect of negotiating directly with trusts, bereft of the large-area epidemiological, public health, and resource allocation - in short, planning - skills of the old Health Authorities (perhaps SHAs will be able to make these up; perhaps the implicit theory is correct that the firsthand experience of PCT staff will tell them what to commission and from whom). Between the centre and the PCTs, SHAs and trusts, there will be nothing.

The Executive, product of a decade and a half of Conservative labour, will be abolished. Regions, which had been folded into it, will then be reformed. There will be four new, Portugal-sized super-regions: one combining the Northwest, the Northeast, and Yorkshire/Humberside; one combining the West Midlands, East Midlands, and East of England; one combining the Southwest and Southeast; and London. They will have two roles. First, they will be regional outposts of the centre, working on performance management and overseeing the activities of other units in the name of the centre. Second, they will be charged with integrating health and social care. The desire to integrate health

and social care has been present for a long time, seems to promise better care and use of resources, and has been formally and partially in practice achieved in Northern Ireland. Nevertheless, why health and social care - responsibilities of trusts and local government mostly - can best be integrated by four such large units is not at all clear. This marks the final elimination of the old NHS regions, once major, autonomous, actors and increasingly reduced to outposts of the centre.

Public health, meanwhile, is to be moved into new Integrated Public Health teams on the regional level by 2002 (DoH 2001a; Greer 2001). These will be composed of the old region-level public health teams, and will be housed in the Government Offices for the eight English regions (the London team is already up and running, and participates in a group of organisations designed to bring together the Greater London Assembly, Mayor, NHS and other partners). There, their functions will be to incorporate public health concerns into the activities of other parts of the government. There are significant worries, however, that the result will damage the NHS capacity to carry out less political/policy aspects of public health work. These tasks, such as screening, identifying populations at risk, and outreach, currently done by Health Authorities, will have to be done by the PCTs. Whether PCTs will consistently have the money, inclination and staffing to do serious public health work of this type is unknown. The Public Health groups in the Government Offices will not have the resources to do that kind of work, and the regional level is too far away from the users for them to do it (the Government, partly after prodding from a Commons Committee, is aware and seeking to use its usual tool of performance management to make PCTs invest in public health - DoH 2001a). This is a risk the devolved administrations all avoid.

As for management, in his speech to the Modernization Agency, Milburn announced more freedoms and extra funds for high performing PCTs, and has since proposed that high performing managers could take over underperforming organisations within the NHS (Guardian, 26 June 2001, p.5) A fudge in these plans is that efforts to transfer resources to the front-line have tended to stop somewhere just above the front line - in an interview, a PCT manager agreed that she, and not the GPs, was where every effort from Whitehall or the Executive stopped. The administrative tasks of a PCT mean they cannot be run only by committees of doctors, while the strategic health authorities, replacing many functions of the Executive, look set to grow in place of regions - to the extent that PCTs are not forced to each develop their own analytic functions. In a tracking project on PCTs, a major problem turns out to be lack of managerial staff to organise the commissioning - a goal slightly at odds with the theory that PCTs will lead to primary care professionals controlling commissioning (Wilkin, Gillam, and Smith 2001).

At any rate, the NHS will have hived off public health, long marginal and virtually reduced to epidimiology for many, to the English regions. And it will have organised its core health care services in a way that might not be more efficient, might not actually move resources to the front line, but will at least not offer tempting region-sized bits of health care services to attract regional politicians.

3b   Wales

The first notable aspect of Wales - and Scotland, and (to a fault) Northern Ireland - is that its post-devolution policy developments may be treated at much shorter length than those

in England. England has not only embarked on a new round of reform since devolution; it has also been in a storm of controversy and confusion about the extent of private sector participation and the nature of the public services, while the organisational features of the service are to be redesigned yet again, with their shape made known largely by leaks and press briefings. As a result, English health policy is both more confused and more difficult to treat in short sections, while Welsh policy, with one serious exception, is far easier to characterise.

The next notable aspect of Welsh health policy is the intellectual departure marked by its strong focus on health outcomes rather than health care, a focus that becomes particularly clear when placed next to the English plans. The Welsh health plan *Improving Health in Wales* (NAW 2001) came out in January 2001, six months after the July 2000 launch of the English *NHS Plan.* Comparing the logics of the two plans is instructive. If the English NHS plan is a strategy to use investment in health care in order to rebuild and reform the NHS, the Welsh plan proposes to use public funds to alter health outcomes. The shift in focus does not so much mean that the Welsh do not propose to invest in health care services as that the Welsh plan attempts to target investment in health care services towards achieving broader goals. *Improving Health in Wales* thus proposes, for example, strategic activity directed towards improving access to health care services and mental health services. This requires working across borders between government (and voluntary) agencies and levels as well as investment in health care resources. Likewise, improving access requires connections with local government and social series. By contrast, the English NHS Plan was devised through wide-ranging consultations in and studies of - the NHS. Thus, its structure explains how each group connected with the NHS, whether staff, patients, or professionals, will change and see change. Wales, by contrast, proposes to direct health services organisational investment toward specific overall health outcomes.

Like its English counterpart, *Improving Health in Wales* proposes to redirect activities by directing investments and changing priorities of workers on the ground. It emphasises its Welshness and its focus on health in society: 'This is a plan made in Wales and designed to meet Welsh needs' writes the health minister in her introduction, going on to refer back to the public health document *Better Health: Better Wales* as a 'starting point' and the origin of the plan's focus on 'preventing disease, substantially improving the health and well being of people; bringing up the level of those with the poorest health up to the level of those with the best; improving the health and well being of children; and encouraging individual responsibility for health' (p.5). In other words, the overall Welsh health strategy is based on intellectual goals set out in a public health document. Given the social power of specialists and professionals in medicine, the intellectual power of the medical model, and the political power of both, this is a strikingly different strategy from those historically followed, or those being followed, in the rest of the UK (and developed world).

Within its goal and strategy-oriented conception of health care, the plan suggests a strong focus on primary care. In this its logic is similar to the one adopted in England and strung throughout Northern Irish consultation documents (and world opinion, ever since the WHO suggested it in the 1970s), that primary care should be the heart of the health care system on account of primary care professionals' greater capacity to monitor patients, and the much lower cost of primary compared to specialist and acute care. The document then

treats acute and specialist care with relatively uncontroversial suggestions, and then spends almost its entire length on broad public health goals that require primary care and public health to bear the main burden, as well as significant mentions of Cinderella services such as mental health. It promises cross-cutting programmes to treat special groups; the NSF from CHI will structure policy for the elderly, while children are to become a major Welsh priority (reflecting, still, the legacy of children's homes scandals in Wales over the last decade).

A flurry of documents in late July 2001 clarifies some issues. The update on the Plan for Wales 2001 (National Assembly for Wales, 2001c) stressed the achievements of the government, most of them in funding services and plans to target specific problems. Funding improvements, the most dramatic actions of the Welsh government, include free prescriptions and dental care for under-25s and over-60s and frozen maximum charges for both (pp7-8). The document then lists goals, most of them distinctly aspirational but focused along the same lines as *Improving Health in Wales.* Meanwhile, the government, having promised in the original *Improving Health in Wales* plan to eliminate health authorities, issued a consultation paper, *Improving Health in Wales: Structural Change in the NHS in Wales* (2001d). This paper began to specify the logic behind the decision and the replacement structures.

The Minister, Jane Hutt, had been much criticised for announcing the abolition of the Authorities in the plan before having a clear plan in place for their replacement. Since details are key in health, and the announcement had almost none, it might be of little comfort to those working in the Service that the strategies ended up retaining theoretical continuities with previous Welsh health policy. The first page of the document with details (National Assembly for Wales, 2001d:l) stresses that the Welsh health policy is now to be organised on two levels: the national and the local. Welsh health policy had always tended to take advantage of the country's small size and structure health services that way, reflecting that Wales is smaller than most of the English NHS regions. However, the Minister's promise, and the consultation document on how to carry it out, take this to a new level by abolishing health authorities. The new Welsh structure will push authority even far down by effectively transferring most responsibilities of the old health authorities to the Local Health Groups. The result will be that the Local Health Groups become Local Health Boards which will have some members of local government and the public on the boards and which will subsume the health authorities' functions, leaving the Trusts alone. This is supposed to make the structure simpler for patients to understand, accountable, and more democratic (National Assembly of Wales 2001d:l-2, 4). Why merging health authority functions into the new Boards is a good way to achieve that, and why these rather than other issues became priorities remains unclear, but it is at least in line with a programme that simultaneously hands power to the local area and the centre. The only problem is that until now health authorities were thought to be local, and it is hard to see how local health groups will be any more local than the old health authorities, or any less bureaucratic or opaque.

The upshot of this is that the Welsh organisational changes move Wales along on its distinctive trajectory, one that combines an English-style determination to force responsibility downward and upward with a commitment to population health and the wider determinants of health that appears in theory and in organisation to be stronger than that of England. The consultation document *Improving Health in Wales: The Future of*

Primary Care (National Assembly for Wales, 200le) spells out a cogent analysis of the changing role of primary care and the current situation in Wales (the latter is an important issue, especially since the unbalanced demographics of Wales make primary care important in areas poorly connected to hospitals). *The Future of Primary Care* bears down on holism, trying to fix the role of primary care within the whole system.

3c   Scotland

Scotland also produced a health plan, in December 2000. This plan, *Our National Health: A plan for action, a plan for change,* like the others, at first could look like a ragbag of unrelated ideas, and was indeed criticised by the opposition in the Scottish parliament for being so. It does, certainly, contain a staggering number of instructions to different bodies in the health system, many of them unspecific ('rapid access chest pain clinics will be further developed' - p.68). However, painting with a broad brush, it has distinct intellectual features, combining, as it does, a Welsh attitude towards the role of public services with an English focus on health care. In many ways it is the most classic of the three health plans: the Welsh plan is an intellectual departure in terms of its focus on social outcomes, the English plan a departure for its (since then increased) determination to rethink the nature of public services and the justification for the NHS. The Scottish plan for the NHS, meanwhile, is about the Scottish NHS.

The Scottish plan's intellectual thread is the health service, within the context of an early chapter that sets out the needs for improving health in general. There is a great deal of attention to public health issues and to issues that must be dealt with by involving health and other services; unlike the Welsh plan, however, the protagonist remains the NHS. Its response to the need for integrated working between health and other sectors takes the form of discussing what the duties of each sector of the health care service will be with regard to supporting patients of a particular type. Thus, the plan specifies the links that the health service will need to make in order to treat teens properly, to treat unsafe sex properly, to treat the elderly properly (compare the Welsh plan, in which the goal - treating children, for example - is presented along with an undifferentiated list of all the groups needed to achieve the goal, including the health services, and how they will relate).

Nevertheless, the goals of the NHS are both internal (such as 'improving the patient's journey') and external (such as coping with and reducing heart-unfriendly practices and unsafe sex). This reflects in many ways the old logic of the paired 1998 papers on public health and health services: the NHS is to cooperate with others to achieve a goal, and particular plans will spell out how the various partners will achieve the goal. Again, there is no reason a plan should be criticised just for focussing on the health service. Issues such as manpower and education are absolutely critical to the future of the NHS, and they get much longer and more elaborate treatment in the Scottish and English plans than in the Welsh (a focus on education in health plans might reflect not so much capacity problems - Wales certainly needs clinicians - as density of teaching hospitals, something neither England nor Scotland lack, but which are rare in Wales).

As for the role of the public service, *Our National Health* makes no serious promises to rethink the role of public sector staff. It lacks the overall tone of urgency that the English *NHS Plan* adopted; there are no hints that the public services in Scotland are teetering on the

edge of an abyss. Thus, the tone is constructive improvement: the public services, as they change, should change in specific ways that will, for example, improve staff learning and ease the patient's dealings with the system. In this sense, the Scottish plan, in all its length and structural similarity to the English one, is notable for the absence of threats to completely reform - or even contract out - the system (admittedly, the references to such novelties in the English plan were easy to miss until the Secretary of State began to present them as the basis for serious challenges to classic public service models).

As with Wales, the Scottish plan included an administrative reform that would both allow the minister to make a mark while still follow the country's political and policy trajectory. Wales eliminated agencies and pushed power down; Scotland integrates organisations more, as explained in a 2001 document explaining the mergers to NHS elites. Scotland is merging the trusts that had already had their boards merged, eliminating administrative autonomy for subunits of boards (the first, Tayside, began work in September 2001). The NHS, outside GPs, will be fifteen large unitary organisations under the Executive. This urge to merge might in part might reflect the sense that administrative autonomy of the trusts has turned out to be a lot of autonomy. In organisational charts, there is nothing stopping JIFs (joint investment funds between primary care and acute trusts); they almost seem redundant, given that the organisations share boards. In practice, JIFs have been rare and hardly successful, reflecting the real power of trust heads. The change being considered by minister Susan Deacon would combine them into single organisations, with single corporate identities: NHS Glasgow will be the name for the whole of the NHS in Glasgow. Furthermore, their boundaries might be altered, reducing the number of health boards from 15 to seven or eight, for reasons that seem unclear (it is suggested by some Scottish observers that seven or eight boards would be more amenable to central control from Edinburgh than fifteen). This change is logically derived from the presumptions in the 1998 reforms - what better way to get partnership on paper than by marrying the partners? - and, the merger proposals aside, would fit with the tendency in Scottish health policy to recreate a theoretically pyramidal health care organisation. There should be resistance, since in Scotland as in the rest of the UK the autonomy of individual trusts is one of the most popular remnants of the internal market. The real likelihood that a super-board will control an isolated GP, an entrenched and popular community hospital, or a high-profile teaching hospital remains, as in all systems, doubtful.

3d   Northern Ireland

Despite the general unpopularity of GP fundholding among its political parties, Northern Ireland is the only place in the United Kingdom where it remains. Progress on structural change was extremely slow. Despite the commitment to abolish fundholding, the old internal market structure was extended and extended. The Assembly was occupied with its own problems, and the health minister especially, while the public agenda was largely concerned with funding squeezes.

Northern Irish devolved health policy got off to a rocky start in the hands of a Sinn Fein minister, Bairbre de Brun, who had little expertise in health policy and rapidly found herself in controversy. Symbolically, the first decision she made as minister was to pulp letterhead for her sprawling department of Health, Social Services, and Public Safety and reprint it in

Irish and English. More dramatically, she was soon to abruptly intervene to settle a dispute over maternity services in Belfast, choosing to maintain services in a Catholic constituency, and close them in a Protestant area. This provoked a significant outcry, both for the sectarian implications that had dogged the issue for some time and for the political pressure and mishandling of the decisionmaking process, and ended up in the courts.

Amidst such polemic, the Northern Irish government has still not been able to replace fundholding, as the plan proposed by the Minister was turned down by the parliamentary committee in January 2001 (on January 27 , the committee decided to prolong fundholding for another year). Despite the general desire to end fundholding, the Minister failed to convince other members that there was a coherent replacement in mind with a thought out transition. As a result, the logjam of consultation documents and ideas will continue to build up; *Fit For the Future* (DHSS 1999) appears to be dying, or to have died, a mysterious death.

This raises an interesting question, as Northern Ireland has unwittingly made itself a laboratory of what has happened after a decade of the internal market. Given the obvious collapse of the quasi-market across the UK in the early 1990s, it is something of a mystery how the system works on the ground after such a long spell without effective policy intervention by the state. It is also creating a problem, as the Northern Irish acute care sector needs serious examination and, probably, major reorganisation of resources according to coherent planning. Currently there are more small, mostly rural but also urban, hospitals than occupancy requires, and several are in danger of being rationalised out of existence as they lose their certification (certification losses can easily come from low volume - a rarely performed procedure in a hospital is a dangerous procedure).

There are two major documents now that respond to the problems of Northern Ireland (there are others; de Brun is criticised precisely for too many consultations on too many topics, and not enough policy). The first was the *Programme for Government,* a document voted in by the Assembly (NIE 2001). It has substantial health content (albeit much of it aspirational). More importantly, in a suspended, recessed, or otherwise halted Northern Irish administration, it is the work plan for the civil service, health elites, and others.

Much Northern Irish policy amounts to deferred maintenance: after decades of rule from London, there are many areas in which policy is outdated, irrelevant, dysfunctional, or unrelated to the needs of the population. The *Programme for Government* sets out to at least make a dent in the legacies of problems in areas such as environmental health, and start to catch up with the public health thinking and work of the three British administrations. This backlog of work might explain why there were so many things upon which the fractious Northern Irish parties could agree; it also explains why it is plausible to expect them to keep working to it. Nevertheless, it is a least-common-denominator set of health policies. Most tellingly, it does very little to treat the highest profile issues of health care: organisation, finance, planning, and resource allocation. On the other hand, it is not a feeble agenda, and it contains enough to allow the civil servants and health service to work on its more technical points even if the political oversight is in abeyance.

Its recommendations are focussed on five areas. First, the document proposes strategies and (mostly) goals in public health, such as improved basic healthy living indicators and action plans on issues such as drugs and specific diseases. These are the sorts of public health issues that span the UK, and that preoccupy all of its governments. Second, the plan

takes on Northern Ireland's serious environmental health issues. These action points touch on issues such as achieving a low incidence of BSE, progressive elimination of the backlog of unimplemented EU legislation on air, land, and water quality; and general efforts to improve the quality of air, water, and land beyond that. It is striking to see environmental health classified as health, given Northern Irish politicians' historic lack of interest in the wider determinants of health. Third, it then arrives at health services, or the areas most Northern Irish politicians tend to view as health, and here proposes largely consultations, setting target dates for strategies. The only concrete policies are some extra staff and capital investments in two hospitals, reducing backlog in safety work on buildings, and investing in information technology. Fourth, it then has concrete, implementable goals in improving social care, such as more care packages and staffing changes. Finally, in the near term it also has implementable policies on improving attention to children, such as increasing coverage in the Sure Start programme and issuing new child protection guidance. In short, the document could be agreed in large part because of Northern Ireland's backlog of issues needing attention. The sluggishness of direct rule (and the sluggishness of the Assembly) mean that there are many such areas deserving attention.

The second, and more daring, document was the 'Hayes Report,' the product of a commission set up to review the structure of acute care. Handed this politically dangerous topic, the committee opted to view acute care within the structure of the entire system, and thus ended up (among other conclusions) suggesting rationalisation of health and social services boards and making some specific suggestions about how policymakers would want to think about fitting in primary care. Much of the document is focused on hospitals, reflecting its remit, and it makes a clear case for developing a local hospital model that would fit in as an intermediate stage, reinforcing primary care, avoiding high-end procedures that are best centralised, and feeding into high level institutions (a model similar to that adopted in several other systems, including Catalonia, in order to provide hospital services in areas that cannot sustain high level tertiary care). The report also makes concrete recommendations for some hospital downgrades (from worrisome tertiary care to local hospital) and other changes, changes that would be politically dangerous - hospital changes are one of the few ways to create tactical coalitions in the Assembly that crosscut sectarian divides. It had explosive effects in the southwest, where it proposed that a new hospital be built in Enniskillen rather than Omagh and thus prompted major lobbying efforts by Omagh partisans (Irish Times, 2001).

It endorses, promotes, and seeks to work within a general trend of shifting care from top-level to lower-level hospitals, and from local hospitals to primary care, taking advantage of technology to both reduce the investment in expensive tertiary care while increasing the availabilities of procedures. Here, however, it butts up against the continuing inability of the Northern Irish Assembly to replace primary care. While there is little support for internal market mechanisms in Northern Ireland, fundholding and any primary care commissioning model would not necessarily mean that the government had appropriate policy tools with which to decide service patterns. The Hayes report (which broadly endorses *Fit for the Future),* is a convincing blueprint for the future of most of the Northern Irish health system, but acting upon it would require a political actor with the resources and inclination to expend on a health policy. There is none right now, and neither a review of the Good Friday

agreements nor some form of suspension or reversion to direct rule would give any players the power and desire to reshape health policy. Thus, it seems that the Programme for Government, with its focus on public health issues, legitimacy from the Assembly, and high quotient of technical content, is to shape Northern Irish health policy in the near future. Northern Ireland will be concentrating on clearing up its backlog of public and environmental health, and fixing or expanding its link between health and social services and its staffing issues.

4 *Concluding notes*

Due to their shared heritage of the UK-wide NHS, all four systems began with similar raw materials and similar new focuses on the professionals' causes of quality and public health. Reflecting this, the major axes of differentiation are the attention to health outcomes as against health service outcomes and the extent of planning versus market-based strategies such as primary care commissioning. The English NHS is focussed on health outcomes; the *NHS Plan* is about the NHS; and the threat to eliminate regional functions and devise residual NHS regions that do not work with other English regions hardly looks like an effort to promote joint working for health outcomes. There are targets and objectives in the English plan; they are just targets for traditional health players such as hospitals and clinicians. The Welsh plan, by contrast, targets outcomes and regards the NHS as a tool in the policy mix. The Scots are in the middle: their plan conceptually is structured as the English, with a focus on how health care services are delivered, but it has long lists of the ways the health care system should reach out from its core functions to promote improvements in health.

One of the first striking attributes about health policy since devolution is the steadily increasing complexity of English health politics compared to the others - the English NHS, already unsettled in the mid-1990s, is now undergoing yet another obscurely radical transformation and its public sector principles are being hotly debated. The slower pace and greater consistency of change in Scotland and Wales, by contrast, raises one interesting question and might answer another. It raises the question: what are the attributes of English policymaking that make it so unstable? The initial evidence for this instability lies in the fact that when a piece of the UK was politically devolved, it stopped the constant reforms that marked UK health policy and continue to mark English health policy. And it might answer the question: what would the NHS look like if a single organisational structure and set of priorities were allowed to bed down and become institutionalised? For decades NHS staffers have complained that they could do a good job running the service if they were freed of constant reorganisation. This conviction looks like it might be put to the test in Wales or Scotland, where those policy changes being mooted are directly in line with the direction of health policy since 1997 and might plausibly be the last ones.

Finally, a caveat. These three sections have focused on policy documents and the formal shape of health care organisation. They have neither included much research into implementation nor day-to-day political tracking; they are about policy design. This obscures some issues. It gives the outcomes of policymaking, but does not directly attack the policymaking processes. It does not speak to the speed and efficiency of implementation or unforeseen consequences of policies. Likewise, the extent to which budgets reflect these priorities is not a part of this report. This alone means that this document is not an overall picture, since most of the high profile political issues have been about funding, especially Scotland's decision to fund long-term care for the elderly (see Nelson 2001). Staffing, likewise, is not yet a feature of organisational design and thus does not appear to the same extent that it appears in discussions of the health systems.

One major feature, noted in all systems, is that of the relationship between the political and health care spheres (as against policy shifts). In each devolved administration, there had been a tradition of autocratic policy (especially over the two decades of Conservative rule in Scotland and Wales that was unmatched by any Conservative victories in the countries). In Scotland, most pronouncedly, it led to an elite-led form of decision making in which the professions, civil servants, and other stakeholders dominated the closed arenas within which most decisions were taken. The result is the upsurge in political intervention in and accountability for the health services. It can be seen as positive - members of devolved assemblies point out that this is the first time that the devolved health systems have been accountable to elected officials. It can also be seen as negative, as members of the health services, accustomed to greater importance in a more technical environment, adjust poorly to 'micromanagement' by ministers and parliamentarians of governments (for whom health is one of the biggest tasks).

These issues, prominent in the monitoring and annual reports of the Devolution and Health project, lead to some different conclusions: for example, the small size of Scotland and Wales has led to unprecedented access not only to ministers, but also *by* ministers, leaving trust heads much closer to politics than they have traditionally been. In all systems, but especially England, micromanagement has also meant highly distorting targets, including the infamous waiting list targets that have badly distorted health care priority setting. Target setting also puts pressure on managerial resources and leads to a constant threat of media activity, and is a major complaint of participants. Finally, micromanagement can also come through the back door, as quality agencies rope in practitioners and commissioners (in England) and leave them with very little room to manoeuvre. These are all issues that afflict the systems, although Scotland, Wales and Northern Ireland are more preoccupied with new issues of accountability and political direction while England still faces forms and targets.

Meanwhile, the line between micromanagement and accountability has yet to be drawn (if such a line can indeed be drawn): there is almost always a case for leaving a decision to experts, yet devolution, and a democratic state, presume that decisions should be transparent to, and often made by, the elected representatives of the populace. Currently, there has not been enough time for the health policy system to be open to capture, and the press (especially the Scottish press) have done their part to call for action on particular issues or diseases. Thus, ministers have incentive to intervene in order to gain headlines; the question is of the extent to which this might distort longer term clinical priorities. Otherwise, involvement and oversight by members of the assemblies is a point on which there is still friction: a call from a committee or a member can be a rude shock to a health service manager. It seems from interviews that the short term line between the political and the technical will be drawn where the parliamentarians run out of capacity to scrutinise (in Scotland, MSPs say they have had to think seriously about what aspects to scrutinise, given the demands on MSPs' time and staffing that even one big scandal, such as that in Tayside acute care, can have). Likewise, ministers also have learning curves in working out how much they can know about a system and how much they can do to change it. This is not a problem that afflicts only scrutiny-heavy devolved parliaments, for there have been many opportunities in recent decades to wonder about the pragmatism of English health policy.

These issues are in their ways more visible, as both complaints of micromanagement and demands for more of it occupy the press. They are also to some extent part of any political system, and the alternative - produce capture of policymaking - is not desirable on democratic grounds. Only the extent to which they systematically vary and change policy and habits over time will influence the particular design of the system. Health care system design, by contrast, is slower, but has great capacity to hint at different alignments of power and different trajectories of health policy. The comparisons in this document and the Devolution and Health project are intended to gain the advantage of a comparative study of these different trajectories. Even when half-baked or radical, such changes fall into distinct logics that reflect their societies and political systems, and make it rewarding to study the logics of policies despite all the rhetoric that surrounds them.

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NB: The background to developments since devolution is the collection of Constitution Unit monitoring reports on Scotland, Wales, and Northern Ireland and the document/news collections, online along with some studies of regionalisation in English health at www.ucl.ac.ukj/constitution-unit/d&h

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Annexe
Comparison of NHS Plans

NHS Scotland; *Our National Health - A plan for action, a plan for change*
NHS Wales: *Improving Health in Wales - A plan for the NHS with its partners*
The NHS Plan: *A plan for investment, a plan for reform*

Category	Scotland	Wales	England
Diet and exercise	• Fresh fruit in schools • Diet action plan • Physical Activity Task Force • Healthy Living Centres	• *Promoting health and well being - Implementing the national health promotion strategy* • Est. an expert group to assess the evidence and advise on means of improving diet and nutrition	• Advice on diet and exercise at local surgeries • Reform of welfare foods programme • New National School Fruit Scheme
Smoking, drugs, and alcohol consump-tion	• Ban tobacco advertising • Education initiatives • Target Scotland's share of tobacco tax to create a national health Improvement Fund		• Nicotine Replacement Therapy available on prescription • Increase the participation of problem drug users in drug treatment programmes by 55% by 2004, and 100% by 2008
Infectious diseases	• Infection control policy • Investment of £3m in 'Healthy Respect Programme'- promotion of sexual health		• New sexual health strategy
Pregnancy and parent support	• Maternity Services Framework to be published		• Reduce rate of teenage conception by half by 2010

	• Each NHS Board to have antenatal and postnatal education programmes • Sure Start Scotland		
Children	• Health Promotion • Provision of integrated service • Children with learning disabilities to have support • Child Health Services Template		• Expansion of Sure Start projects • New Children's Fund
Elderly	• Local service for shopping laundry and minor household repairs • Response teams • Free home care support for up to four weeks following discharge from hospital • Commission for the Regulation of Care Homes to be established.	• Publish National Service Frameworks for the elderly • Est. an expert group to assess the evidence and advise on means of improving diet and nutrition • Develop proposals for provision of intermediate care facilities	• **Total of £1.4b for new investment in better health and social care services for the elderly** • *Intermediate Care* - rapid response and hospital-at-home teams - intensive rehabilitation services - £900m investment in new intermediate care and related services • New National Service Framework to be published • Pilot an NHS retirement health check • Care Direct • Reform funding system for residential care • Nursing care to be fully funded

Specific diseases:			• Routine screening to be extended
Coronary Heart Disease	• Introduce National Service Frameworks in coronary heart disease(CHD), cancer and mental health • CHD Task Force to produce National Plan encouraging a healthy lifestyle and diet • Maximum wait for angiography will be 12 weeks • Maximum wait for surgery or angioplasty will be 24 weeks from time of angiography • Creation of a national database on CHD • Investment in cardiac rehabilitation services throughout Scotland	• CHD care targets set by National Service Framework Implementation Plan to be met • Est. performance measures • Nec. revascularisation procedures within 12 months, within 6 months by 2003 and 3 months by 2005 • Following a myocardial infarction they will receive thrombolysis treatment within 20 mins of arriving at hospital • Est. of body to oversee plan • Development of 3 managed clinical networks for cardiac care in Wales	• invest £230m pa in heart disease services by 2003 • No. of cardiologists to increase by 10% each year, other staff increases • disease management registers • rapid chest pain clinics - access within two weeks • improve ambulance response times - 75% within 8 mins • 75% of eligible people to receive thrombolysis within 20 mins of hospital arrival • cut waiting times for surgery - 6 months by 2003, 3 months by 2005 • Coronary Heart Disease Programme - streamline delivery of care • **Reduce mortality rate from heart disease by at least 40% in people under 75 by 2010**
Cancer	• Scottish Cancer Plan to include new national targets for maximum waiting times	• Cancer care minimum standards to be enforced	• 50 new MRIs, 200 new CAT scanners, 80 new liquid cytology units, 45 new linear accelerators

	• Breast cancer treatment to begin within one month of diagnosis • Maximum wait from urgent referral to treatment for children's cancers and acute leukaemia will be one month • By 2005 maximum wait from urgent referral to treatment for all cancers Will be two months • Expand screening programmes • Managed Clinical Networks for all cancer service • Information Task Group to develop access to information	• Consultant appointment within 10 days of receipt by hospital of an urgent referral • Diagnosis and appointment for treatment as set in the Wales Cancer Services Co-ordinating Group min. standards • Increasing access to specialist nurses • Development of 3 managed clinical networks for cancer care • GP referral guidelines • Cancer Information Strategy	• extra £570m a year in cancer services by 2003/04 • breast screening extended to women aged 65-70, and other screening programmes extended • introduce prostate cancer screening, Prostate Cancer Action Plan • New NHS Cancer Research Network • **Reduce mortality rate from cancer by 20% in people under 75 by 2010**
Child mental health services		• Est. child centred service • Build services on a four tier framework of primary or direct contact services: specialist teams and very specialised interventions and care	• 50 early intervention teams to be established.
Mental Health and Learning Disabilities	• Extra £2m for projects linked to the Framework agenda for improved care and access to care • Increase Mental Illness Specific Grant	• Publish National Service Frameworks for mental health	• Extra annual investment of over £300m to fast forward the National Service Framework

	• Develop liaison psychiatry • Investment of £4m over three years in campaign to promote positive mental health and wellbeing • Investment of £5m to improve facilities in mental health hospitals • Investment of £36m for people with learning disabilities		• 1000 new graduate primary care mental health workers and 500 more community mental health staff • Prison services - all people with sever mental illness will be in receipt of treatment • Est. of combined mental health and social care trust
Women's mental health			• Women only day centres in every health authority
Physical Disabilities	• Improve physical access to health services		
Palliative Care	• Managed Clinical Network Approach to be developed		
Diabetes	• Launch Scottish Diabetes Framework including plans to establish a national screening strategy	• Publish National Service Frameworks for diabetes	
Staff	• Family friendly policies • New Leadership Development Programme • £6m to help implement the Education, Training and Lifelong Learning Strategy	• New national human resources and payroll system • Professions experiencing shortages to produce own Recruitment and Retention strategy • Action Plan for Staff Involvement	• 7500 more consultants, 20000 extra nurses, 6500 extra therapists • 1000 more medical school places • extra pay in shortage areas, and new pay system

• Strategic partnership to be formed with the Scottish University for Industry to bring advantages of electronic learning • New nursing and midwifery strategy • New strategy for the professions allied to medicine • Increases in numbers of nurses, midwifes, consultants, junior doctors and the professions allied to medicine • Possibility of fast-track graduate-entry into medical degrees in Scotland • Develop a strategy for pharmacy • Introduction of long service awards and good service awards • Reform the current distinction awards scheme to ensure that most of any new awards go to those consultants who make the biggest contribution to delivering and improving health and healthcare locally • Make Personal Medical Services pilots permanent	• Career development plans • Health Leadership Centre for Wales - leadership devpt. • Staff representation on NHS Boards • Give GPs opportunity to work in A&E, occupational therapy in GP practices etc.	• childcare support, with 100 onsite nurseries • New Performance Framework for Human Resources and Improving Working Lives standard • Invest extra £140m in personal devpt. and training • International recruitment • 2000 more GPs by 2004 • Bigger role for GPs in shaping services • Encourage an expansion of Personal Medical Service contracts • Reward consultants who make biggest commitment to NHS • Junior doctor's hours will continue to fall • Nurses to have the right to prescribe a limited range of medicines • Extra £140m by 2003 to support a major programme of training and development for all staff • Individual learning account of £150pa or dedicated training to NVQ level two and three

	• 210 extra nurses this year • 10,000 extra nurses by 2005		• Leadership development
Hospitals	• Diet improvements • Investment in A&E of £1m • Decrease wait for inpatient care from 12 to 9 months • Eradication of mixed wards - investment of £4.8m	• Look to integrate hospital based emergency care with other forms of provision • Review of highly specialised hospital services for children • Increase general and critical bed capacity • Diet improvements	• *'Traditional waiting lists for surgery will become a thing of the past.'* • Referrals to specialised units • New generation of *'state of the art* hospitals - more intimate ward bays or rooms will become the norm • Patient Advocate and Liaison Service in every hospital to resolve complaints quickly • Dietary improvements • Personal bedside TV and telephone for every patient • 7,000 extra beds in hospitals and intermediate care • Over 100 new hospitals in the next 9 years • Clean hospitals - £30m allocated, cleanliness inspections, national standards, Board member to take personal responsibility for monitoring hospital cleanliness

			• Dietary improvements - national franchise for catering to be examined, extra £10m a year • By 2004 waits should be limited to 4hrs in A&E • Booked appointment system - by 2005 waiting lists for hospital appointments will be abolished • Max. wait for in-patient care to be reduced to six months • Increased security for high secure hospitals - 200 extra long term secure beds
Drugs	• Remove inequalities • Electronic transmission of prescriptions • Increase no. of nurses trained to prescribe drugs, and the range of what they can prescribe	• Freeze prescription charges at their present level and provide free prescriptions to all those under the age of 25	• Harness the benefits of advances in genetic technology • NHS Direct will provide *'a one-stop gateway to healthcare'* - will offer option of ordering prescription and arrange for delivery to patient's door • Nurses to have the right to prescribe a limited range of medicines

Primary Care:	• Access to an appropriate member of the primary health care team within 48 hrs	• Develop the extended primary care team, adopting, wherever poss., a single-roof policy • Waiting times for elective treatment to be as good as, if not better than, the best in the UK	• NHS Direct will provide *'a one-stop gateway to healthcare*[1] - will offer option of ordering prescription and arrange for delivery to patient's door • Book appointments on-line • Electronic patient records • Multi-purpose premises - GPs, nurses, pharmacists, dentists, therapists... • Est. new level of primary care trusts - provide for even closer integration of health and social services - *Care Trusts* • Patients to be able to see a primary health care professional within 24hrs and a GP within 48hrs • Free and nationally available translation and interpretation service will be available on every NHS premises
Oral Health	• Free toothbrushes and toothpaste and fissure programme for young children	• Find further ways of rewarding NHS dentists	• Fund more dental access centres • Reward dentists' commitment to NHS

Optometry		• Introduce free dental checks for the under 25s and for those aged 60 or over • Freeze the maximum dental charge at its present level • New free eye care service, to detect eye-diseases *Detailed targets to be made for effective primary care, improvement of waiting times and organisation of services*	
NHS Direct etc.	• NHS24 • Telemedicine - investment of £5m	• NHS Direct • Telemedicine	• NHS Direct • NHSplus-occupational health service • Digital TV will enable people to tune into channels dedicated to health issues
Clinical Governance		• A new clinical governance strategy due to be published in 2001 will include the development of performance indicators and the introduction of a new National Assembly-based Clinical Governance Support Unit	
R&D	• Est. Public Health Institute for Scotland	• New National Advisory comttee for research and development	• Continue work on genetics

| Public Involvement | • Invest £14m over 3 years to *'build the capacity of the NHS to communicate with, and listen to and work in partnership with individuals and communities'*.
• Patients Project
• Patient held smart cards
• Telephone and internet based feedback | • New Health and Social Care Charter
• Internet site offering instant access to a comprehensive range of health services
• Patients will have the right to receive copies of correspondence between clinicians about themselves
• Increased feedback in hospitals
• New complaints system
• Enhance accountability
• Communities First programmes - £83m available | • Expert Patient Programme will be extended
• Letters between clinicians about an individual patient's care will be copied to the patient as of right
• Patient held smart cards
• Wider range of information will be published about each GP practice
• Est. mandatory reporting scheme for adverse healthcare events
• Abolish NHS Tribunal - power to suspend GP to be devolved to health authority
• New rights of redress
• NHS Charter to replace Patients Charter
• Increased feedback
• Patient representation increase, e.g. one third of members of new NHS Modernisation Board will be citizen and patient representatives |

| Capital Investment | • Cardiac rehabilitation services
• Extra £2m for mental health care projects
• £36m for people with learning disabilities
• £4.8m to eradicate mixed wards
• £11m in the redesign of A&E | • Capital investment plans for 5 years - PPP, public sector and govt
• Est. inventory of major items of equipment - enable strategic management of replacement investment
• Replacement of lifesaving equip.
• Current discretionary capital allocations available to Trusts to increase by£10mby2005 to deal with maintenance and equipment replacement
• Centrally funded capital programme will increase to £47m | • 7000 extra beds in hospitals and intermediate care by 2004 of these 2100 will be in general and acute wards
• 1700 extra non-residential intermediate care places
• 30% increase in adult critical care beds over the next three years
• Over 100 new hospitals by 2010
• 500 new one-stop primary care centres
• Over 3000 GP premises modernised
• 250 new scanners
• Modern IT in every hospital and GP surgery
• Annual real term growth of 6.3%
• In partnership with the private sector we will also develop a new generation of Diagnostic and Treatment Centres
• New buildings:
- £7b of new capital investment through an extended role for PFI
- 40% of the NHS estate will be less that 15 years old by 2010 |

			- clear at least a quarter of its £3.1b maintenance backlog
			- **The new buildings will be provided through a mixture of public capital and an extended role for the PFI.**
			• 50 new MRIs, 200 new CAT scanners, 80 new liquid cytology units, 45 new linear accelerators, 3000 new automated defibrillators in public places, 450 new haemodialysis stations
			• An extra £250m invested in information tech by 2005
			- Electronic booking of appointments, prescribing of medicines, NHSnet, telemedicine
			• Invest £230m pa in heart disease services by 2003

Scotland - 'rebuilding Our NHS'

'Decision making in the NHS is still too complex, too fragmented and over-layered. Each NHS Health Board and NHS Trust is monitored and held to account separately. Each has separate planning mechanisms and plans …

… there is a desire to return to a *National* Health Service delivering *national* standards …

… It must be answerable for its actions both to the Scottish Parliament and to local communities. But it must also be given the space to get on with the job of delivering and improving services.'

'Now is not the time for further major structural change in the NHS but it is time to bring the Health Service back together as a single system, underpinned by a national identity and a national approach to health and service improvement… The proposals in this Plan are not about restructuring the system, but about rewiring it to recreate a truly National Health Service.'

'We believe there is great scope for better integration and rationalisation of functions and service delivery arrangements at a local level. We also recognise that 'no one size fits all'.

- In each of the 15 NHS Health Board areas there will be a single unified NHS Board.
- In the 12 mainland NHS Health Board areas, these new unified Boards will replace the separate board structures of the existing NHS Boards and NHS Trusts.
- These new NHS Boards will form a single local health system, with single governing boards.
- Local Authorities should have a strong voice on the new NHS Boards.
- In each NHS Board area, the existing separate Health Improvement Programmes and NHS Trust Implementation Plans should be replaced by a single comprehensive document - a Local Health Plan.
- NHS Trusts will retain their existing operational and legal responsibilities within the local health system but with streamlined management arrangements and fewer non-executive directors.
- Chairs and Chief Executives of NHS Trusts will sit on the new unified NHS Boards and be held jointly accountable for the performance of the local health system.
- Introduction of joint resourcing and joint management of community care services locally, starting with services for older people.
- Legislation, if necessary, will be passed to remove any barriers to joint working between the NHS and social work and housing departments.
- Health Technology Board for Scotland will provide the principal source of advice on the clinical and cost effectiveness of new health technologies and drugs. (To work closely with the National Institute for Clinical Excellence in England.)

NHS ENGLAND: a Plan for Investment, a Plan for Reform

Some of the 'Must Do Targets'

- Reduce the maximum wait for an outpatient appointment to 3 months and the maximum wait for inpatient treatment to 6 months by the end of 2005
- 2/3 of all outpatient appointments and inpatient elective admissions will be pre-booked by 2003
- Guarantee access to a primary care professional within 24 hrs and to a primary care doctor within 48 hrs by 2004
- Cleanliness and food
- Reduce substantially the mortality rates from major killers by 2010; from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75; and from suicide and undetermined injury by at last 20% - National Service Frameworks.

Changed systems for the NHS

- New system of devolved responsibility
- Core national standards and targets
- Modernisation Agency to support best practice and improvement
- Independent publication of performance information
- Independent inspection to assure quality
- A new £500m performance fund
- Intervention in failing health organisation
- Inclusive ways of running the NHS

'There will be maximum devolution of power to local doctors and other health professionals … the centre will: set standards, monitor performance, put in place a proper system of inspection, provide back up to assist modernisation of the service and, where necessary, correct failure. Intervention will be in inverse proportion to success.'

- New Modernisation Agency to help local clinicians and managers redesign local services around the needs and convenience of patients. It will encompass the existing National Patients' Action Team, the Primary Care Development Team, the 'Collaborative Programmes' and the clinical governance support unit. The NHS Leadership Centre will also become the responsibility of the new Modernisation Agency, as will the Beacon Programme and the NHS annual awards programmes. The Agency will work with all Trusts to support continuous service improvement.

- Five changes are being made to the way performance standards are set and information is collated and published:

1) Introduction of a complementary version of the Performance Assessment Framework that specifically applies to all NHS Trusts as well as primary care trusts providing community services.
2) Develop proposals for improved measures of performance.
3) Responsibility for the annual publication of the results of the Performance Assessment Framework will be transferred to the Commission for Health Improvement.
4) Every GP practice and primary care group/trust must have in place systems to monitor referral rates from every GP practice.
5) New efficiency targets will be set.

- Inspection needs to be subject to independent scrutiny
1) The Commission for Health Improvement will inspect every NHS organisation every four years.

- New incentives and earned autonomy
1) New system of incentives.
2) Classification as 'green', 'yellow' or 'red'.
3) The green-light organisations will be rewarded with greater autonomy and national recognition.
    - automatic access to the National Performance Fund
    - lighter touch monitoring
    - greater freedom to decide the local organisation of services
    - have the ability to take over persistent failure red light organisations

- Organisation
    - Modernisation Board est.
    - Combine responsibility for public health function, the NHS, and social services in a single chief executive post at permanent secretary level with more autonomy and operational control. The CE will account to the Modernisation Board.
    - No. of small Task Forces to drive forward implementation of the plan e.g. waiting, heart disease, mental health, older people, children, inequalities and public health, the workforce, quality, and the capital and information systems infrastructure.
    - New written performance agreements between regional offices of the Department and the CE.
    - Regional directors to be counter-signatories of annual performance reports.
    - Regional and local modernisation boards and taskforces.
    - Appointment of non-exec directors of trusts and health authorities will pass to a new arms-length body - a new NHS Appointments Commission, which will report annually to Parliament.
    - Decisions on the outcome of major health service reorganisatons will in future be based on the recommendations of an independent panel - a National Independent Panel comprised of doctors, nurses, and other health professionals, patients' and citizens' representatives, and managers of the 'green light' health authorities in equal proportion.

Changes in the Relationship Between the NHS and the Private Sector

- Concordat between the NHS and private providers
- Public-private partnerships to modernise NHS services
- Expansion of clinical trials for new drugs
- NHSplus to offer occupational health services for employers

NHS care will remain free at the point of delivery, whether care is provided by an NHS hospital, a local GP, a private sector hospital or by a voluntary organisation.

There will be a national framework for partnership between the private and voluntary sector and the NHS to help primary care groups and trusts when they commission services. This will include a set of national guidelines - a concordat which will highlight three particular areas for co-operative working: elective care; critical care; intermediate care. The concordat will also cover: the involvement of private and voluntary sector organisations in the development of local health planning; the development of locally agreed protocols for referral, admission and discharge into and out of NHS and private and voluntary facilities; greater exchange of information between the two sectors about workforce and other capacity issues, and about clinical activity. The NHS will explore with the private sector the potential for investment in services such as pathology and dialysis.

A new policy on research governance in the NHS will be published by the end of the year. By April 2001, new ways of streamlining the work of research ethics comttees will have been developed, allowing faster and more effective recruitment of patients into clinical trials.

'Working with the private sector is not just a one way arrangement. The NHS also has a lot to offer industry and employers; ill health has a big effect on the economy ... A portfolio of NHS occupational health services will be identified which can then be bought, in whole or in part, by employers to improve the health of their employees. NHSplus will be established as a national agency. The business plan for NHSplus will ensure these new services are provided at no cost to the taxpayer ... NHSplus will be launched in 2001 ...'

NHS WALES: Improving Health in Wales - A Plan for the NHS with its Partners

Health Care Challenges: Organisation of clinical services:
'The future requires that services will be delivered across wide geographical areas in a co-ordinated, multidisciplinary and integrated manner … We will use clinical networks to make optimal use of resources and increase the number of patients seen … They will be made up of NHS partners and health professionals from within each health economy. Their objective will be to ensure that appropriate expertise is available to all patients so as to improve the outcomes of treatment.'

The People's NHS: Public and patient involvement
°To enhance accountability:

• Membership of Local Health Groups will be extended to include representatives from local authority members;
• The public will play a much more significant role in the NHS Wales public appointments process, including active involvement in the appointments process;
• Chief Executives will be held accountable for the implementation of public involvement activities within their organisation;
• By December 2001, all NHS Trusts and Local Health Groups will carry out a baseline assessment of their arrangements to deliver public involvement activity;
• By April 2002, all NHS Trusts and Local Health Groups will produce an annual plan setting out proposals for public involvement and patient focus. The National Assembly will produce guidance by December 2001 to support this process.'

Partnerships for health: joint working
'Local Health Groups will have an advanced role in commissioning health and health-related social care services …

… The new Strategic Partnerships for Health and Well Being, which remove many of the financial and accountability barriers to joint working, provide a unique vehicle to ensure strategic leadership and commitment. These new bodies will be responsible for taking forward the commitment to improved co-ordination set out in the partnership agreement Composed of elected members of each local authority and of senior representatives of the local health organisations, these Strategic Partnerships will be responsible for giving direction to, and committing resources for, joint working across the whole range of health and local government services …

… At the operational level, the commissioning, planning and review of joint working will rest with Local Health Groups …

… To develop synergy between Health Improvement Programmes, Local Health Group Action Plans, NHS Trust Business Plans, Local Authority Social Care Plans, Children and

Young People's Plans, Drug and Alcohol Action Plans and Community Strategies, partners need to come together to review their achievement against common goals and commitments on an annual basis … For this purpose:

- The National Assembly will, by January 2002, develop with the NHS and its partners a series of public service accountabilities. These will form part of the new performance management frameworks for both health and social services. They will help the new Strategic Partnerships for Health and Well-being to monitor and evaluate the progress of member authorities in serving the community, both for services for which it has prime responsibility and for its contribution to joint working and partnership building;
- Local Health Groups will, over the next two years, progressively take the lead in developing these partnerships and implementing the new 1999 Health Act flexibilities. The National Assembly will monitor progress on this as a key part of these public service accountabilities …

The National Assembly, NHS Wales and local authorities will set in hand arrangements for the independent sector provision to be included in the overall planning for health and social care and in training and development programmes.'

Managing Improvement
'A Standing Expert Group involving representatives from all the main groups will make recommendations for strengthening performance management … New accountability arrangements for the NHS in Wales will be issued early in 2002 and further strengthened with the structural changes signalled by this Plan.'

Managing the Future Together
'In order for this plan to succeed we need to strengthen our capacity at two different levels'
   At local level: strengthen and develop role of LHGs - will take on new responsibilities of commissioning and delivering health care in their localities.
   At the national level: the Plan involves a new assertion of the National Assembly's direct democratic control of its health responsibilities.
   'All this removes the necessity for Health Authorities in Wales, abolishing a tier current hierarchy between the Assembly and the patient'
   The Assembly's statutory responsibilities will be supported by a new Health and Well-being Partnership Council chaired by the Minister for Health and Social Services.
   The NHS Trust's main functions will remain unchanged as will their statutory position, but their responsibilities will be discharged via new lines of accountability.